

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

MARGUERITE MARION,)
Plaintiff,)
v.)
BANK OF AMERICA, NATIONAL)
ASSOCIATION,)
Defendant.)
Case No. 08 CV 3867)
Judge Virginia M. Kendall)
Magistrate Judge Geraldine Soat Brown)

**BOA'S MEMORANDUM OF LAW IN SUPPORT OF
ITS MOTION TO DISMISS THE COMPLAINT**

Defendant Bank of America Corporation¹ (“BOA”), by its attorneys, submits this Memorandum of Law in Support of its Motion to Dismiss the Complaint.

INTRODUCTION

On June 10, 2008, Plaintiff Marguerite Marion (“Marion”) served BOA with the complaint in this case, which she had previously filed on May 20, 2008, in Illinois state court. On July 8, 2008, BOA removed this case to this Court based on federal question and diversity jurisdiction.

Marion's Complaint, Counts I-III, seeks to recover unpaid incentive/severance bonus benefits. Count I alleges a violation of the Illinois Wage Payment and Collection Act ("IWPCA"); Count II alleges a violation of the Illinois Sales Representatives Act ("SRA"); and Count III alleges a violation of the Illinois "Earned Bonuses" Administrative Code.

Count IV seeks to recover medical insurance benefit coverage. It alleges a violation of the federal Consolidated Omnibus Budget Reconciliation Act (“COBRA”), as well as three parts

¹ The Complaint incorrectly names the Defendant as “Bank of America, National Association.”

of the Illinois Insurance Code: the Illinois Continuation Law, Dependent Child Continuation Law, and Spousal Continuation Law (“Illinois Insurance Code claims”).

BOA moves to dismiss Marion's complaint because:

1. Count's I-III are claims for incentive/severance bonus benefits that are only available under an ERISA severance plan. As such, those claims are preempted by ERISA and must be dismissed because Marion has not pursued or exhausted the severance plan's ERISA-mandated administrative claim procedures. Count III must be dismissed for the additional reason that there is no separate cause of action under the Illinois “Earned Bonuses” Administrative Code.

2. Count IV's federal COBRA claim is a claim for medical insurance benefit coverage that is only available under an ERISA medical insurance benefit plan (or its successor). As such, that claim must be dismissed because Marion has not pursued or exhausted either medical insurance benefit plan's ERISA-mandated administrative claim procedures.

3. Count IV's Illinois Insurance Code claims are likewise claims for medical insurance benefit coverage that is only available under an ERISA medical insurance plan (or its successor). As such, those state law claims are preempted by ERISA and must be dismissed because Marion has not pursued or exhausted either medical insurance plan's ERISA-mandated administrative claim procedures. In addition, those claims must be dismissed because there is no private cause of action under the Illinois Insurance Code.

FACTUAL BACKGROUND

I. The Bonus and Severance Pay Plans

Marion's complaint alleges that she was wrongly denied incentive bonuses under the ABN AMRO Group Corporate Incentive Plan (“CIP”) and the ABN AMRO Group Long Term Incentive Plan (“LTIP”), both of which were instituted by BOA's predecessor, LaSalle Bank

Corporation, then part of ABN AMRO Bank NV (“LaSalle”). (Cmplt. ¶ 6). Those programs specifically provided that an employee who terminated during a plan year was not ordinarily entitled to any incentive bonus for that year.² (Ex. 1, pp. 5-6 and Ex. 2, pp. 3-4). The ABN AMRO Group Severance Pay Plan (“LaSalle Severance Plan”), titled after LaSalle’s then owner, filled the termination year gap by including such bonuses as severance. Both the CIP and LTIP programs confirmed that a former employee may be vested at the time of termination if the employee “meets all of the requirements for the payment of severance pay under the [LaSalle Severance Plan] (including without limitation execution of the Waiver and Release Agreement referred to therein).” (Ex. 1, p. 5; Ex. 2, p. 3)

On September 30, 2007, as a result of LaSalle’s concomitant sale to BOA, the LaSalle Severance Plan was amended so that it “shall be frozen in its entirety and no benefit thereunder shall be available to any person who terminated employment . . . after September 30, 2007.” (Ex. 3, Amendment). Instead, the former LaSalle employees who BOA terminated after September 30, 2007 were eligible to receive severance benefits under the BOA Corporate Severance Plan (“BOA CSP”).

The BOA CSP, like the frozen LaSalle Severance Plan, treats the CIP and LTIP termination year bonuses as severance. In that regard, BOA gave the former LaSalle employees

² Without converting BOA’s motion to dismiss to a motion for summary judgment, the Court may consider and rely upon documents outside the pleadings if they are referred to in Marion’s Complaint and are central to her claims. *See Wright v. Associated Ins. Cos.*, 29 F.3d 1244, 1248 (7th Cir. 1994); *Venture Assoc. Corp. v. Zenith Data Sys. Corp.*, 987 F.2d 429, 431-32 (7th Cir. 1993); *Feigl v. Ecolab, Inc.*, 280 F. Supp. 2d 846, 849 n.2 (N.D. Ill. 2003) (SPD considered on motion to dismiss when referred to in complaint and central to claim). Marion’s Complaint (¶¶ 6, 9-10, 12-16, 23, 24) specifically references the CIP, LTIP, her “severance package,” and her “medical insurance.” As such, the CIP, LTIP, LaSalle Severance Plan, Guide to the Corporate Severance Program – Legacy LaSalle Bank Corporation, BOA CSP, BOA CSP summary plan description, LaSalle Group Medical Plan summary plan description, and BOA Medical Plan summary plan description are attached as Exs. 1-8, respectively.

it terminated a “Guide to the Corporate Severance Program – Legacy LaSalle Bank Corporation,” which summarizes the eligibility requirements and severance benefits available under the BOA CSP. The Guide expressly provides that “[e]ligible employees will receive severance for annual incentive programs in which they participate.” (Ex. 4, p. 6). Similarly, like the frozen LaSalle Severance Plan, the BOA CSP requires an employee to execute a release agreement. (Ex. 4, pp. 3-4, 8; Ex. 5, p. 4; Ex. 6, p. 185).

II. Marion's Employment

LaSalle employed Marion until September 30, 2007, when BOA acquired LaSalle. (Cmplt. ¶ 7). BOA continued Marion’s employment until December 15, 2007, when BOA eliminated her position. (Cmplt. ¶ 9). After her BOA termination, Marion, like other former LaSalle employees, was still eligible for continued medical insurance benefits coverage under the self-insured ABN AMRO Group Medical Plan (“LaSalle Medical Plan”) until April 1, 2008, at which point eligibility switched to BOA’s Medical Plan, under which most options are self-insured. (*see generally* Ex. 8).

Shortly after BOA decided to terminate Marion’s employment, it asked her to execute the BOA release agreement titled “General Release and Program Agreement” (“CSP Agreement”), in order to become eligible to receive severance benefits, including her CIP and LTIP bonuses. (Cmplt. ¶¶ 9, 13; *see also* Ex. 1, p. 5; Ex. 2, p. 3; Ex. 4, pp. 3-4, 8; Ex. 5, p. 4; Ex. 6, p. 185). Marion refused to sign the CSP Agreement because it contained a non-solicitation-of-customers provision. (Cmplt. ¶¶ 10-11). Thus, Marion did not receive any severance benefits. (Cmplt. ¶ 16).

Marion now alleges that BOA wrongfully failed to pay her CIP and LTIP bonuses in violation of the IWPCA, the SRA, and the Illinois “Earned Bonuses” Administrative Code.

(Cmplt. ¶¶ 19, 25, 29). Further, Marion alleges that BOA refused to continue her medical insurance benefits coverage in violation of COBRA and the Illinois Insurance Code. (Cmplt. ¶¶ 20-26).

ARGUMENT

I. Legal Standard For Motion to Dismiss

FRCP 12(b)(6) provides that the Court may accept as true the well-pleaded allegations of the complaint, but must dismiss the complaint if it does not allege a set of facts upon which the court can accept jurisdiction and upon which relief can be granted. *See Conley v. Gibson*, 355 U.S. 41, 45-46 (1957). The Court must dismiss the complaint “if it is clear that no relief could be granted under any set of facts that could be proved consistent with the allegations.” *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984).

II. The BOA CSP Is An ERISA Welfare Benefit Plan.

ERISA sets the requirements for an employee welfare benefit plan. 29 U.S.C. §§ 1002(1), 1003; *see* 29 C.F.R. § 2510.3-1(a)(3). To qualify, there must be “(1) a plan, fund or program, (2) established or maintained, (3) by an employer . . . (4) for the purpose of providing . . . severance benefits, (5) to participants or their beneficiaries.” *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986) (citing *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982)). Further, a severance benefit plan is a plan for “benefits whose provision by nature requires an ongoing administrative program to meet the employer’s obligation.” *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987); *Collins v. Ralston Purina Co.*, 147 F.3d 592, 595-97 (7th Cir. 1998) (key manager retention agreements were covered by ERISA because the employer “faced the prospect of multiple payments to various managers, at different times,” and the agreements required the employer “to exercise discretion on an ongoing basis”).

The BOA CSP is an ERISA welfare benefit plan because it meets all these requirements. The BOA CSP provides severance benefits for Plan participants, and requires the Plan Administration Committee to make multiple and ongoing payments to eligible employees. (Ex. 4, pp. 6, 8; *see* Ex. 5, p. 6). The BOA CSP also provides that the “Committee shall have discretionary authority to determine eligibility for and to construe the terms of the Plan . . .” and “such other discretionary authority as may be necessary to enable it to discharge its responsibilities under the Plan . . .” (Ex. 5, p. 6.)

Severance plans like the BOA CSP are considered ERISA welfare benefit plans. *See Panaras v. Liquid Carbonic Idus. Corp.*, 74 F.3d 786, 789 (7th Cir. 1996) (noting that a severance plan is an “employee welfare benefit plan”); *Bongiorno v. Assocs. in Adolescent Psychiatry, S.C.*, No. 93 C 2740, 1993 U.S. Dist. LEXIS 11262, at *11-12 (N.D. Ill. Aug. 13, 1993) (noting that “the meaning of welfare benefit plan should be construed liberally” and “[g]enerally speaking, severance benefits will be found to be covered by ERISA”).

III. Marion’s State Law Incentive/Severance Bonus Claims Require Reference To And Interpretation Of The BOA CSP.

Resolving Marion’s Count I-III state law incentive/severance bonus claims for breach of the IWPCA, the SRA, and the Earned Bonuses Administrative Code will require reference to and interpretation of the BOA CSP. The CIP and LTIP programs provide that an employee who terminates during the plan year ordinarily is not entitled to any incentive bonus. (Ex. 1, pp. 5-6 and Ex. 2, pp. 3-4). After the LaSalle Severance Plan was frozen on September 30, 2007, the only vehicle by which a terminated LaSalle employee is entitled to CIP and LTIP bonuses is through the BOA CSP. Under the BOA CSP, otherwise unavailable termination year incentive bonuses are treated as severance (Ex. 4, pp. 6, 20).

To recover under the IWPCA, the SRA, and (theoretically) the “Earned Bonuses” Administrative Code, Marion must show that BOA improperly denied her benefits to which she was entitled under the BOA CSP. Critically, to be eligible for benefits under the BOA CSP, the employee “must sign, and not revoke, a general release and settlement agreement” (Ex. 4, pp. 3-4, 8; Ex. 5, p. 4; Ex. 6, p. 185). Because the BOA CSP governs whether Marion is entitled to the benefits she seeks, resolving Marion’s IWPCA, SRA, and Earned Bonuses claims will necessarily require reference to and interpretation of the BOA CSP.

IV. ERISA Preempts Marion’s State Law Severance Pay Claims.

ERISA preempts Marion’s Count I-III state law incentive/severance bonus benefit claims because these claims require the Court to make reference to and interpret the BOA CSP. ERISA § 514(a) expressly provides that ERISA “supersede[s] any and all State laws” that “relate to any employee benefit plan” governed by ERISA. 28 U.S.C. § 1144; *Sembos v. Philips Components*, 376 F.3d 696, 703 (7th Cir. 2004). A state law or claim “relates to” an ERISA plan if it “has a connection with or reference to such a plan.” *Sembos*, 376 F.3d at 703 (citing *Ingersoll-Rand, Co. v. McClendon*, 498 U.S. 133, 139 (1990)); *see also Kreutzer v. A.O. Smith Corp.*, 951 F.2d 739, 743 (7th Cir. 1991) (“ERISA preempts all state claims for severance benefits”).

Further, ERISA completely preempts “any state-law cause of action that duplicates, supplements, or supplants” ERISA remedies. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). This doctrine of “complete preemption” is based on the exclusivity of ERISA’s civil enforcement provision, ERISA § 502(a). 29 U.S.C. §1132(a); *Davila*, 498 U.S. at 208-09; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987), *overruled on other grounds*, 538 U.S. 329, 341 (2003).

As the Supreme Court explained in *Davila*, Congress enacted ERISA with the intention of making “employee benefit plan regulation . . . ‘exclusively a federal concern.’” 542 U.S. at

208 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). To reach that goal, Congress established an “integrated enforcement mechanism” in the remedial provisions of ERISA § 502(a). *Davila*, 542 U.S. at 208.

To serve Congress’s “purpose of creating a comprehensive statute for the regulation of employee benefit plans,” courts cannot allow states to create and enforce claims that provide alternative or additional remedies for allegedly erroneous plan benefit denials or plan administration practices: “The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.” *Id.* at 208-09 (quoting *Pilot Life*, 481 U.S. at 54). Accordingly, the Seventh Circuit has found that ERISA preempts a state law claim if the claim requires the court to interpret or to apply the terms of an employee benefit plan. *See Collins*, 147 F.3d at 595; *see also Panaras*, 74 F.3d at 795 (quoting *Rice v. Panchal*, 65 F.3d 637, 644 (7th Cir. 1995)) (“complete preemption of state law claims ‘is required where a state law claim cannot be resolved without interpretation’ of a contract or plan governed by federal law”).

As a result, ERISA completely preempts Marion’s state law incentive/severance bonus benefit claims, and they must be dismissed. *See Dabertin v. HCR Manor Care, Inc.*, 177 F. Supp. 2d 829, 857 (N.D. Ill. 2001) (plaintiff’s IWPCA claim for severance benefits was preempted by ERISA because it “would require the court to interpret the terms of the Plan”); *Hamilton Sundstrand Corp. v. Healey*, No. 01 C 50199, 2001 U.S. Dist. LEXIS 16415, at *18-19 (N.D. Ill. Oct. 12, 2001) (claimants’ IWPCA claims for severance benefits were completely preempted by ERISA).

V. Any ERISA Claim For Benefits Must Be Dismissed For Failure To Exhaust The BOA CSP's Administrative Remedies.

The only way any of Marion's Count I-III state law incentive/severance bonus benefit claims could survive preemption is if they are interpreted solely as an ERISA claim for benefits. Yet any claim so interpreted must still be dismissed because Marion has not exhausted the BOA CSP administrative remedies.

The BOA CSP contains a detailed internal claims procedure for participants who believe they are entitled to benefits:

An Associate or other person (the "claimant") who has a claim for benefits under the Plan must submit a written notice of such claim to the applicable Participating Employer. All claims must be submitted within six months from the date the claim for benefits arose. . . The claim shall be decided within 90 days by the Participating Employer . . . Written notice of the decision on such claim shall be furnished promptly to the claimant. . . A claimant may request a review of [a] decision denying the claim. Any such request must be filed in writing with the Committee within 90 days after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information which the claimant wishes to be considered. . . Written notice of the decision on review shall be furnished to the claimant within 60 days . . . following receipt of the request for review. The written notice of the decision by the Committee or its delegate shall include specific reasons for the decision and shall refer to the pertinent provisions on which the decision is based. . . *No legal action concerning the claim may be brought by the claimant unless all of the following have occurred: (1) The claimant has submitted a claim. (2) The claimant has been notified that the claim is denied. (3) The claimant has filed a timely written appeal with the Committee for review of the denied claim. (4) The claimant has been notified in writing of the decision of the Committee or its delegate or the Committee or its delegate has failed to take any action on the request for review within the time prescribed above.*

(Ex. 5, pp. 7-8 (emphasis added); *see* Ex. 6, p. 192).

Although ERISA "is silent as to whether exhaustion of administrative remedies is a prerequisite to bringing such civil action . . . [,] application of the exhaustion doctrine in ERISA cases by requiring a claimant to exhaust administrative remedies prior to bringing suit is a matter within the discretion of the trial court." *Kross v. Western Elec. Co., Inc.*, 701 F.2d 1238, 1244

(7th Cir. 1983). The Seventh Circuit has repeatedly supported district courts' exercise of such discretion by requiring plaintiffs pursuing ERISA claims to exhaust their administrative remedies. *See, e.g., Zhou v. Guardian Life Ins. Co.*, 295 F.3d 677, 679 (7th Cir. 2002) ("As a prerequisite to filing suit, an ERISA plaintiff must exhaust [her] internal administrative remedies") (citations omitted); *Gallegos v. Mt. Sinai Med. Ctr.*, 210 F.3d 803 (7th Cir. 2000); *Robyns v. Reliance Standard Life Insurance Co.*, 130 F.3d 1231 (7th Cir. 1997).

The court has outlined strong policy reasons for doing so:

[I]t has long been recognized in this Circuit that the intent of Congress is best effectuated by granting district courts discretion to require administrative exhaustion. This policy of judicial administration furthers the goals of minimizing the number of frivolous lawsuits, promoting non-adversarial dispute resolution, and decreasing the cost and time necessary for claim settlement. Furthermore requiring administrative exhaustion enables compilation of a complete record in preparation for judicial review.

Gallegos, 210 F.3d at 808 (citing *Powell v. AT&T Comm., Inc.*, 938 F.2d 823, 825 (7th Cir. 1991); *Kross*, 701 F.2d at 1244; *Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 649 (7th Cir. 1996)).

Marion does not allege that she filed a claim for severance benefits under the BOA CSP and does not plead exhaustion. Accordingly, the Court should dismiss her Complaint. *Gupta v. Freizenet, USA, Inc.*, 908 F. Supp. 557, 565 (N.D. Ill. 1995) (granting 12(b)(6) motion to dismiss due to failure to plead exhaustion); *Jackson v. Kroch's & Brentano's, Inc.*, No. 93 C 1333, 1993 WL 245295, at *5 (N.D. Ill. June 30, 1993) (dismissing ERISA claim because plaintiff "fail[ed] to allege that he availed himself of, much less exhausted, the internal grievance procedure").

VI. Count III Must Be Dismissed For The Additional Reason That There Is No Separate Cause of Action Under The Illinois Earned Bonuses Administrative Code.

Marion's Count III claim for relief under the Illinois "Earned Bonuses" Administrative Code must also be dismissed because the Illinois Administrative Code does not provide a

separate cause of action from the IWPCA. Rather, the Earned Bonuses provision in question is an administrative regulation, promulgated by the Illinois Department of Labor pursuant to Section 9 of the IWPCA.³ That implementing statute provides Marion with a cause of action to recover any unpaid bonus. Thus, the regulation does not give rise to an additional, separate cause of action. Indeed, Complaint Count I is precisely such an IWPCA claim. Accordingly, the Count III claim under the "Earned Bonuses" Administrative Code must be dismissed for this reason as well.

VI. Count IV's Federal COBRA Claim Must Be Dismissed Because Marion Has Not Pursued or Exhausted the ERISA-Mandated Administrative Claim Procedures of Either the LaSalle Or BOA Medical Insurance Benefit Plans.

Count IV appears to allege a claim for COBRA benefits. But the LaSalle Medical Plan, which provided continuing coverage to former LaSalle employees until April 1, 2008, and the BOA Medical Plan which succeeded it, both have detailed internal claims procedures for employees who believe they are entitled to benefits (Ex. 7, Important Plan Information, p. 14-15; Ex. 6, p. 193).

While Marion alleges discussions with various persons, she does not allege she filed a claim for benefits pursuant to either plan and does not plead exhaustion of either plan's appeal procedures. Accordingly, Marion's failure to pursue the administrative remedies under those plans requires her COBRA-based claim for benefits to be dismissed for the same reasons as set forth in Section V, *supra*. *See also Wilczynski v. Lumbermens Mut. Cas. Co.*, 93 F.3d 397, 404 (7th Cir. 1996) (recognizing the same exhaustion principles apply to a claim for COBRA benefits); *Anglero v. Anglero*, No. 05 cv 5422, 2005 U.S. Dist. LEXIS 35520, at *5 (S.D.N.Y.

³ ILWPA Section 9 provides that the "Department shall establish rules to protect the interests of both parties [the employer and the employee] in cases of disputed deductions from wages." 820 ILCS 115/9.

Dec. 22, 2005) (summary judgment for failure to exhaust administrative remedies regarding COBRA benefits claim).

**VIII. Count IV's Illinois Insurance Code Claims
Must Be Dismissed On The Basis of ERISA Preemption.**

Just as Marion's state law claims for her incentives/severance bonus benefits are preempted by ERISA, so too are her Count IV Illinois Insurance Code claims for continued medical insurance benefits. The LaSalle Medical Plan and BOA Medical Plan are employee benefit plans as defined by ERISA, 29 U.S.C. § 1002(1). In addition, the only LaSalle Medical Plan options Marion was eligible for were self-insured (Ex. 7, p. 2). Most of the BOA Medical Plan options to which Marion might apply are self-insured as well. (*See generally* Ex. 8). As detailed above, ERISA § 514(a) expressly "supersede[s] any and all State laws" that "relate to any employee benefit plan" governed by ERISA, and a state law or claim "relates to" an ERISA plan if it "has a connection with or reference to such a plan." 28 U.S.C. § 1144; *Sembos*, 376 F.3d at 703 (citations omitted). Moreover, the state insurance law exception to ERISA preemption does not apply to self-insured benefit plans. *Reilly v. Blue Cross and Blue Shield United of Wis.*, 846 F.2d 416, 425 (7th Cir. 1988) (ERISA preempted plaintiff's state law bad faith claim because the plan was self-insured); *Health Cost Controls v. Rogers*, 909 F. Supp. 537, 542 (N.D. Ill. 1994) (ERISA preempted Illinois anti-subrogation law where the plan at issue was self-insured).

Because Marion's Illinois Insurance Code claims relate to an ERISA plan, those claims are preempted by ERISA with regard to the LaSalle Medical Plan and the BOA Medical Plan (to the extent she chooses a self-insured option) and must be dismissed. *See Gadsby v. Health Ins. Admin., Inc., et al.*, 522 N.E.2d 865, 869 (Ill. App. Ct. 1988) (ERISA preempts claim that employer failed to notify employee of medical insurance continuation rights in violation of the

Illinois Insurance Code ERISA); *see also Russo v. Boland*, 431 N.E.2d 1294, 1297-98 (Ill. App. Ct. 1982) (where the medical plan is self-insured, ERISA preempted plaintiff's claims for conversion coverage under the Illinois Insurance Code claim). Further, even if Marion's Illinois Insurance Code claims were interpreted as an ERISA claim for benefits, they would have to be dismissed, for the reasons explained in Section VII, because Marion has not alleged that she has exhausted her administrative remedies under either ERISA medical plan.

Moreover, whether or not ERISA preempts Marion's continuation claims with the regard to the BOA Medical Plan, it preempts the remedies that may be available to her under the Illinois Insurance Code. For example, in *Lopez v. The Guardian Life Ins. Co.*, 834 F. Supp. 251, 252 (N.D. Ill. 1993), a case against an insurance company, the plaintiff alleged that the defendant violated the Illinois Insurance Code by failing to notify her that her medical insurance coverage was discontinued. In granting the defendant's motion to dismiss, the court held that the state "may not enforce the [Illinois Insurance] Code by providing an ERISA plan beneficiary a state law cause of action for contested insurance benefits. Such a remedy is exclusively an ERISA concern." *Id.* at 255; *see also Buehler Ltd. v. Home Life Ins. Co.*, 722 F. Supp. 1554, 1562 (N.D. Ill. 1989) (ERISA preempts any possible remedies available to an ERISA plan beneficiary under the Illinois Insurance Code). Accordingly, Marion cannot recover benefits under the Illinois Insurance Code.

IX. The Illinois Insurance Code Does Not Provide A Private Right Of Action.

Marion's Count IV claims under the Illinois Insurance Code must be dismissed for the additional reason that the Code does not provide a private right of action. Rather, the Illinois state legislature delegated enforcement of the Insurance Code to the Department of Insurance.

See 215 ILCS 5/401-07.

The purpose of the Insurance Code and its accompanying administrative regulations is to place conditions on the maintenance of insurance licenses – not to provide remedies to private parties. *Gore v. Indiana Ins. Co.*, 876 N.E.2d 156, 165 (Ill. App. Ct. 2007). As such, Illinois courts have routinely held that there is no private right of action under the Illinois Insurance Code. *Vine Street Clinic et al. v. HealthLink, Inc.*, 856 N.E.2d 422, 439 (Ill. 2006) (plaintiff had no standing to pursue alleged violation of the Illinois Insurance Code because enforcement of the Code was delegated to the Department of Insurance); *Gore*, 876 N.E.2d at 165 (same); *Hamilton v. Safeway Ins. Co.*, 432 N.E.2d 996, 999 (Ill. App. Ct. 1982) (denying plaintiffs' claims for violation of the Illinois Insurance Code because if the legislature “intended to grant a private right of action . . . [it] would have explicitly done so”) (internal quotations omitted); *contra Cas. Ins. Co. v. Hill Mech. Group*, 753 N.E.2d 370, 377 (Ill. App. Ct. 2001) (allowing private cause of action under Illinois Insurance Code where there was no other available remedy).

CONCLUSION

The Complaint, Counts I-III, are claims for incentive/severance bonus benefits that are only available under an ERISA severance plan. As such, those claims are preempted by ERISA and must be dismissed because Marion has not pursued or exhausted the BOA CSP ERISA-mandated administrative claim procedures. Count III must be dismissed for the additional reason that there is no separate cause of action under the Illinois “Earned Bonuses” Administrative Code.

The Complaint Count IV’s federal COBRA claim is a claim for medical insurance benefit coverage that is only available under the LaSalle Medical Plan or its successor, the BOA Medical Plan. As such, that claim must be dismissed because Marion has not pursued or exhausted either medical insurance benefit plan’s ERISA-mandated administrative claim procedures.

The Complaint Count IV's Illinois Insurance Code claims are likewise claims for medical insurance benefit coverage that is only available under the LaSalle Medical Plan or its successor, the BOA Medical Plan. As such, those state law claims are preempted by ERISA and must be dismissed because Marion has not pursued or exhausted either medical insurance plan's ERISA-mandated administrative claim procedures. In addition, those claims must be dismissed because there is no private cause of action under the Illinois Insurance Code.

Accordingly, BOA moves to dismiss the entire Complaint.

Respectfully submitted,

BANK OF AMERICA CORPORATION

By: /s/Kathryn S. Clark
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July 14, 2008

CERTIFICATE OF SERVICE

Kathryn S. Clark, an attorney, hereby certifies that on July 14, 2008, she electronically filed the foregoing **BOA's Memorandum of Law in Support of Its Motion to Dismiss the Complaint** in the United States District Court for the Northern District of Illinois and that a true and correct copy of the same was served upon the following via first class U.S. mail, postage pre-paid:

Laurel G. Bellows
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/s/Kathryn S. Clark
Kathryn S. Clark

Exhibit 1

**ABN AMRO GROUP CORPORATE INCENTIVE PLAN
AS AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2007**

1. PURPOSE

The purpose of the Corporate Incentive Plan (the "Plan") is to provide an incentive to certain officers of LaSalle Bank Corporation ("LaSalle"), and its subsidiaries and affiliates (hereinafter referred to collectively as the "Corporation" and individually as an "Employer"). The Plan was originally established by ABN/LaSalle North America, Inc. as the Annual Management Incentive Plan, and was subsequently adopted by LaSalle, revised and renamed the Corporate Incentive Plan. The Plan is hereby amended and restated in its entirety, effective as of January 1, 2007.

2. DEFINITIONS

- a. "CIP Group" means each line of business, function or services group the officers of which are eligible to participate in the Plan.
- b. "CIP Pool", with respect to each CIP Group, means the total amount of funds available to pay Incentive Awards to all Participants employed by the CIP Group in a Plan Year. The CIP Pools are used solely for the purpose of calculating the maximum amount of Incentive Awards that may be paid, and shall not be construed to require that any funds be segregated for the purpose of paying Incentive Awards.
- c. "Corporate Incentive Plan" or "Plan" means the management incentive compensation plan herein described, as the same may be amended from time to time.
- d. "Incentive Award" or "Award" means any amount paid to a Participant under the Plan.
- e. "Participant" means any employee of the Corporation selected by LaSalle to be eligible to receive Awards under the Plan.
- f. "Performance Metrics" means the financial metrics established by LaSalle for each Plan Year, the achievement of which will determine the extent to which the CIP Pools are funded.
- g. "Plan Year" or "Year", unless otherwise specified, means the fiscal year of LaSalle.
- h. "Target Bonus" means the Incentive Bonus determined by multiplying a Participant's Target Percentage by his or her base salary. If a Participant's base salary changes during a Plan Year, the Base Salary as of the end of the Plan Year will be used.

- i. "Target Funding" for each CIP Pool with respect to a Plan Year means the sum of the Target Bonuses of all Participants eligible to receive an Incentive Award from such CIP Pool.
- j. "Target Percentage" means a percentage assigned to each category of Participants used to determine a Participant's Target Bonus.

3. ADMINISTRATION

The Plan shall be administered by LaSalle. The authority of LaSalle to administer the Plan shall be vested in the Head of the ABN AMRO Business Unit North America ("BU NA"), or the successor to such position, and shall be exercised on his behalf by the Head of Human Resources of BU NA and the BU NA Center of Expertise (CoE) for Rewards. LaSalle shall have all powers and authority necessary for the administration of the Plan, including the authority to: (a) prescribe, amend and rescind Plan rules, regulations and procedures; (b) approve financial performance goals and determine from time to time the eligibility of employees for participation in the Plan; (c) adopt Performance Metrics; (d) determine the amount of individual Incentive Awards; (e) make such adjustments to benefits payable under the Plan as may be necessary or appropriate to correct mistakes of fact; and (f) take any other action necessary or appropriate for the administration of the Plan. The examples in the immediately preceding sentence are listed herein solely for purposes of illustration and not limitation.

4. ELIGIBILITY

Eligibility for participation in the Plan shall be limited to those officers of the Corporation who are selected by LaSalle in its sole discretion in the manner set forth in Section 5 below. Officers who participate in an annual incentive compensation plan sponsored by an Employer, including commission and bonus plans sponsored by any department of an Employer, except the Delivering the Bank Cross Sell Incentive Plan, are not eligible to participate in the Plan, unless there is approval by the BU NA Head of Human Resources in consultation with the BU NA CoE Rewards.

5. PARTICIPANTS

For each Year, each member of the BU NA Regional Management Committee (RMC) or their delegates shall nominate the categories of officers in his or her area who shall be eligible to participate in the Plan for that Year. All recommendations shall be reviewed and approved by the BU NA Head of Human Resources and BU NA CoE Rewards and subject to changes, if any, requested by the Head of BU NA. Each such person eligible to participate in the Plan for a Plan Year is referred to as a "Participant." The BU NA CoE Rewards, in consultation with the appropriate BU NA RMC member shall determine the Target Percentage for each category of Participant. The initial designation of Participants for each Plan Year and assignment of Target Percentages shall ordinarily be made within the first 90 days of the Plan Year, but in no event later than June 1 of the Plan Year.

An employee who is hired during the Year in a category of officers eligible to participate in the Plan, or who is promoted during the Year into a category of officers eligible to

participate (or a category that has a higher Target Percentage) shall receive the Incentive Award payable as if the employee had been a Participant (and with the higher Target Percentage) for the entire year. A participant who is transferred to a category of officers eligible to participate at a lower Target Percentage shall receive the Incentive Award payable as if the employee had been a Participant at the original Target Percentage for the entire year.

LaSalle shall, at the beginning of each Year (or for Participants designated as such during the Year, as soon as practicable after such designation), send a letter ("Notification Letter") to each officer who has been designated a Participant in the Plan for the upcoming Plan Year. The Notification Letter shall indicate for that Plan Year: (1) the Participant's Target Percentage and (2) the Performance Metrics that must be achieved for each Incentive Award Level.

6. INCENTIVE AWARDS

A Participant's award shall be based on the attainment of identified Performance Metrics for the Plan Year, the Participant's individual performance or a combination of both.

a. Performance Metrics. LaSalle shall, during the first 90 days of the Plan Year, establish one or more Performance Metrics consistent with the purposes of the Plan, as determined in the sole discretion of LaSalle, for that Year. One set of Performance Metrics shall be established for the Corporation as a whole. A set of Performance Metrics may be established for each separate line of business, function or services group. The determination of which lines of business, functions or services groups will have separate Performance Metrics will be made by the Head of BU NA in consultation with the CoE Rewards for BU NA and BU NA Finance. Attainment of the Performance Metrics will determine the CIP Pool funding. The Performance Metrics for 2007 are as set forth in Exhibit A.

- (i) Performance Metric Hurdles. For each Performance Metric, LaSalle shall establish a set of increasing goals to be met for the Plan Year, and a funding factor associated with each goal. For example, in 2007 the increasing goals and funding factors are outlined below. In future Plan Years LaSalle may establish a different number of goals and/or different multiples.
 - (A) Minimum: The goal that must be attained before any portion of the CIP Pool is funded for the Performance Metric. The funding factor if the minimum goal is achieved in 2007 is 0.8.
 - (B) Target: The budgeted goal for the Performance Metric. The funding factor if the target goal is achieved in 2007 is 1.0.
 - (C) Overachievement: A goal that exceeds the budgeted goal for the Performance Metric. The funding factor if the overachievement goal is achieved in 2007 is 1.5.

(D) Far Exceeds: A goal that represents performance significantly in excess of the budgeted goal for the Performance Metric. The funding factor if the far exceeds goal is achieved in 2007 is 2.0.

(ii) Weighting of Performance Metrics. The determination of weighting of Performance Metrics for the lines of business, functions or services groups will be made by the Head of BU NA in consultation with the CoE Rewards for BU NA and BU NA Finance. The CIP pool for each line of business, functions or services group for which individual metrics have been designated will fund partly on the achievement of the metrics for the Corporation and/or partly on the achievement of the metrics for the individual line of business, functions or services group. For 2007, the CIP pool for each function and services group will fund 100% based on the achievement of the metrics applicable to the Corporation as a whole, and the lines of business will fund 50% based on the achievement of the metrics applicable to the Corporation as a whole and 50% based on the metrics applicable to that line of business. The percentage of funding contingent on the line of business, functions or services group's performance will be determined during the first 90 days of the Plan Year.

LaSalle may, from time to time during the Plan Year, make such adjustments in Performance Metrics as LaSalle may determine, in its sole discretion, to be appropriate to preserve the degree of incentive in Incentive Awards for the Plan Year in light of acquisitions, divestitures, accounting changes, restructuring charges, and other nonrecurring or nonoperating events.

b. Calculation of CIP Pools. For each Plan Year, the funding of each CIP Pool shall be determined as follows:

- (i) Determine the Target Funding for the CIP Pool, equal to the sum of the Target Awards of all Participants eligible to participate in the CIP Pool for the Year.
- (ii) Determine the funding factor for each Performance Metric based on the level of achievement. If the actual performance falls between two hurdles the funding factor will be interpolated. Multiply this by the Performance Metric's weight.
- (iii) Add the products described in (ii) above for all Performance Metrics and multiply by the Target Funding. The results shall be the funding for the CIP pool.

c. Individual Incentive Awards. The CIP Pool funding, as described above, determines the total amount of Incentive Awards that may be paid to all Participants in a CIP Group. The actual amount of Incentive Award payable to each Participant shall be determined by such Participant's individual performance rating, as determined by the applicable CIP Group management in accordance

with guidelines developed by CoE Rewards for BU NA. The total allocation of the CIP Pool shall not exceed the maximum funding level determined by the Performance Metrics, which in 2007 is two times the Target Funding.

Solely for the purposes of illustration, assume that for a given Plan Year LaSalle has established three Performance Metrics for a given CIP pool, with weightings of 50% for Performance Metric A and 25% for each of Performance Metric B and C. Assume further that the Target Funding for the CIP Pool is \$1,000 and that the CIP Group for the CIP Pool achieves the target goal for Performance Metric A, the overachievement goal for Performance Metric B, and midway between the overachievement and far exceeds goal for Performance Metric C. The CIP Pool funding would be as follows:

Performance Metric	Performance Metric Final Result	Performance Metric Weighting	Performance Metric Final Result x Weighting
A	1.00	50%	.5000
B	1.50	25%	.3750
C	1.75	25%	.4375

$$\text{CIP Pool Funding} = 1.3125 \times \$1,000 = 1,312.50$$

7. VESTING

Except as provided below in this Section 7, if a Participant is actively employed by the Corporation on the date on which Incentive Awards are paid for a Plan Year (the "Payment Date"), he shall be vested, on such Payment Date, in his right to receive his Incentive Award for that Year.

If a Participant is not actively employed by the Corporation on the Payment Date for a Plan Year the portion of his Incentive Award for such Year that vests on the Payment Date shall be adjusted as provided below:

- a. If a Participant dies, becomes fully disabled as defined in the ABN AMRO Group Long Term Disability Plan, or retires under a qualified retirement plan maintained by the Corporation before the end of a Year, then subject to the other provisions of this Section 7, such Participant shall be vested on the Payment Date in the amount of the Incentive Award that he or she would otherwise have been entitled to multiplied by a fraction, the numerator of which is the number of full months he was employed by the Corporation during the Year, and the denominator of which is twelve. Such Incentive Award shall be paid on the Payment Date.
- b. A Participant whose employment is terminated by reason of the elimination or his or her position on or after August 1 of a Year, and who otherwise meets all of the requirements for the payment of severance pay under the ABN AMRO Group Severance Plan (including without limitation execution of the Waiver and Release Agreement referred to therein) shall be vested at the time of termination in his or

her Target Award, multiplied by a fraction, the numerator of which is the number of full months he was employed by the Corporation during the Year, and the denominator of which is twelve. Such Incentive Award shall be paid as soon as practical, but in no event more than 90 days, after his termination of employment.

The balance of a Participant's Incentive Award for any Year that is not vested as provided above shall automatically be forfeited by the Participant as of the date on which the Participant's employment is terminated. Any individual who voluntarily terminates prior to the Payment Date shall forfeit his or her entire Incentive Award. LaSalle, in its discretion, may from time to time provide for accelerated vesting. Certain accelerated vesting provisions applicable to terminations occurring in 2007 are set forth in Exhibit A.

If a Participant transfers employment prior to the end of the performance period to a position with an Employer, or an affiliate of LaSalle that is not an Employer, in which he or she is no longer eligible to participate in the Plan, he will continue to be a Participant and will receive his Incentive Award for the Year provided that he is still an employee of the Employer or affiliate on the Payment Date (or on the date on which his employment terminates pursuant to paragraph (a) or (b)); provided that if as a result of such transfer he becomes entitled to participate in a different annual bonus plan for the same Year his Incentive Award under this Plan will be multiplied by a fraction, the numerator of which is the number of full months during which he participated in the Plan, and the denominator of which is twelve.

Notwithstanding the foregoing provisions of this Section 7, a Participant shall forfeit his entire Incentive Award (whether or not vested) in the event that LaSalle determines:

- (i) that such Participant has been terminated for Cause prior to the last day of the vesting period. "Cause" shall be defined as any of the following, as determined in the sole discretion of Company management:
 - (A) Violation of Company policies and procedures sufficient to warrant termination; or
 - (B) Conviction of, or entry of a plea of guilty or nolo contendere to, a felony or a crime involving dishonesty, theft, breach of trust or sale, manufacturing or distribution of controlled substances, or immoral conduct; or
 - (C) Failure to substantially perform the duties of the employee's position, or
- (ii) that such Participant is guilty of any illegal act or act of misconduct (alone or in conjunction with others) in connection with his employment by any Employer, whether or not such act occurred while he was a Participant hereunder, and whether or not the Participant was terminated by reason of such act; or
- (iii) that such Participant enters into competition (alone or in conjunction with others whether individually or as an employee, partner or 5% or more shareholder of or as an independent contractor with any other person or organization) with or assists

or is employed by or has contracted to render personal services with any other business entity that is in competition with any financial institution that is an Employer.

8. BENEFITS.

- a. Form of Payment of Benefits. All Incentive Awards payable hereunder will be paid in cash.
- b. Time of Payment. Except as otherwise provided for herein, all Incentive Awards for each Plan Year will be paid on the Payment Date, which shall not be later than March 15 of the year following the end of the Plan Year. Commencing with the 2008 Plan Year, a Participant who is otherwise eligible to participate in the ABN AMRO Group Supplemental Savings Plan (the "SSP") may, if permitted by LaSalle, elect by an irrevocable election to defer all or a percentage of the Incentive Award for such Plan Year in accordance with the terms of the SSP. Such election must be made, in accordance with the SSP either
 - (A) prior to the beginning of the Plan Year,
 - (B) if the Performance Metrics for the Plan Year are established not later than the 90th day of the Plan Year, the Participant has been employed since the date on which the Performance Metrics are established, and the Incentive Awards for the Plan Year otherwise meet the requirements for "performance based compensation" pursuant to section 409A of the Internal Revenue Code, not later than June 30 of the Plan Year, or
 - (C) in the case of a Participant who has never previously been eligible to participate in any elective account balance deferred compensation plan maintained by the Corporation or any of its subsidiaries or affiliates, not later than 30 days after the Participant first becomes eligible to participate in the Plan; provided that in such case the total amount deferred shall not exceed the Participant's Incentive Award multiplied by a fraction, the numerator of which is the number of days in the Plan Year after the day the election is made and the denominator of which is the total number of days in the Plan Year.

All Incentive Awards deferred prior to 2007, including limitations and provisions to ensure compliance with section 409A of the Internal Revenue Code, shall be governed by the SSP.

9. DESIGNATION OF BENEFICIARY

In the event of the death of a Participant, all benefits to which that Participant is entitled but which are unpaid at the time of his death shall be paid to the beneficiary or beneficiaries of that Participant who are designated in writing by the Participant or in the absence of any such designation, to the Participant's estate. LaSalle shall determine in its sole discretion whether the Participant has effectively designated a beneficiary, but shall

have no obligation to solicit beneficiary designations, and in any event LaSalle shall have no obligation to any other person as a result of any payment made to a person whom LaSalle has determined in good faith to be the Participant's beneficiary. The Incentive Award for the Plan Year in which the Participant dies shall be paid in accordance with Section 7(b), and any election the Participant had made to defer such payment shall be revoked by his death. Payment for Incentive Awards that the Participant had previously elected to defer shall be paid in accordance with the terms and conditions of the SSP.

10. AMENDMENT OR TERMINATION OF PLAN

LaSalle may terminate, amend or modify this Plan at any time and from time to time; provided however, any such termination, amendment or modification, or any administrative action may not divest any Participant of any of his benefits under this Plan as of the date of such termination, amendment or modification.

11. GENERAL PROVISIONS

- a. **No Right of Continued Employment.** Nothing contained in the Plan shall give any Participant the right to be retained in the employment of an Employer or affect the right of an Employer to dismiss any Participant.
- b. **No Right of Continued Payments.** The receipt of an Award for any Plan year shall not guarantee a Participant the right to receive an award for any subsequent Plan Year.
- c. **No Right to Receive an Award.** A Participant will not be eligible to receive an Award unless the Participant attains the individual goals, if any, approved for such Participant, notwithstanding that the Corporation, or the line of business, function, or services group of which the Participant is an employee, attains its Performance Metrics.
- d. **No Right of Assignment.** The interest of any Participant in the Plan shall not be assignable, or subject to the claim of any creditor.
- e. **Withholding for Taxes.** Each Employer shall have the right to deduct from all amounts paid under this Plan any taxes required by federal, state or local law to be withheld with respect to such payments.
- f. **Law to Govern.** All questions pertaining to the construction, regulation, validity and effect of the provisions of the Plan shall be determined in accordance with the laws of the State of Illinois.
- g. **Special Compensation.** Except as otherwise provided by law, or as explicitly provided in such plan, benefits received under the Plan shall not be included or taken into account in determining benefits under pension, retirement, profit sharing, group insurance, or any other benefit plan maintained by the Corporation; provided that effective January 1, 2007, such benefits shall be considered compensation for purposes of the ABN AMRO Group 401(k) Retirement Savings

Plan. Neither the corporation nor LaSalle guarantee in any way the deferral of tax liability if a Participant defers the payment of Plan benefits.

- h. Funding of Benefits. Benefits payable hereunder to or on account of any Participant shall be paid directly by the Corporation from its general assets. The Corporation shall not be required to segregate on its books or otherwise set aside any amount to be used for the payment of benefits under this Plan.
- i. Interpretation. LaSalle shall have the sole and complete authority to interpret the provisions of and decide all disputes arising under the Plan, which interpretations and decisions shall be final and binding on all parties having any interests arising under or by virtue of the Plan.
- j. Litigation. If any Participant, former Participant or beneficiary shall bring a suit or proceeding against LaSalle or the Corporation, or if any dispute shall arise as to the person or persons to whom payment or delivery of any funds shall be made by the Corporation, the costs (including attorneys' fees) to the Corporation of defending the action, where the result is adverse to the complainant, or pursuant to the authorization of the court or other forum in which the suit or proceeding is brought, shall be charged against the Plan benefits of the applicable Participant, former Participant or beneficiary and only the excess of such Plan benefits, if any, over the amount of such costs shall be payable by the Corporation.

IN WITNESS WHEREOF, the undersigned has caused this Amended and Restated Plan to be executed as of the 27 day of June 2007.

ABN AMRO BANK N.V.

By: Robert J. Mc

By: Jay J. Sch

By: John J. Sch

ANNEEKSE VAN DE WEREF
AS COUNTER SIGNATORY

EXHIBIT A
2007 PERFORMANCE METRICS
AND VESTING REQUIREMENTS

The 2007 Performance Metric hurdles for the Corporation as a whole and each line of business, the weighting of each Performance Metric, and the multiple applied for CIP Pool funding upon the achievement of each hurdle, are set forth below. If the Performance Metric achievement falls between two of the hurdles, the multiple is interpolated.

The three Performance Metrics used for 2007 are:

- (1) Return on Assigned Risk Capital (RoARC) (50% weighting). RoARC equals Net Income/Assigned Risk Capital (i.e., Economic Capital x 1.25).
- (2) Revenue Growth (25% weighting). Revenue Growth equals the percentage increase in current year revenue over prior year revenue.
- (3) Efficiency Ratio (25% weighting). Efficiency Ratio equals Total Expense / Total Revenue.

For 2007 only, the funding of each CIP Pool shall not be less than the Target Funding.

All metrics are subject to adjustment based on changes in the Performance Contract for that Plan Year.

Performance Metrics for the Corporation (excluding Global Clients)
Determines 100% of Funding for all Functions and Services and 50% of Funding for Lines of Business

	Minimum .8 x	PFC Target 1.0 x	Above Target 1.5 x	Far Exceeds 2.0 x
RoARC (average) (50% weighting)	20.1%	20.7%	21.3%	22.1%
Revenue Growth (25% weighting)	0.9%	2.3%	6.5%	10.0%
Efficiency Ratio (25% weighting)	66.9%	65.3%	64.9%	63.9%

Performance Metrics for Commercial Banking
Determines 50% of Funding

	Minimum .8 x	PFC Target 1.0 x	Above Target 1.5 x	Far Exceeds 2.0 x
RoARC (average) (50% weighting)	20.6%	20.9%	21.6%	22.2%
Revenue Growth (25% weighting)	-1.1%	0.5%	5.0%	8.9%
Efficiency Ratio (25% weighting)	46.6%	45.9%	45.2%	44.5%

Performance Metrics for Personal Financial Services
Determines 50% of Funding

	Minimum .8 x	PFC Target 1.0 x	Above Target 1.5 x	Far Exceeds 2.0 x
RoARC (average) (50% weighting)	13.0%	13.8%	15.1%	16.0%
Revenue Growth (25% weighting)	1.5%	2.9%	7.0%	10.6%
Efficiency Ratio (25% weighting)	86.4%	85.1%	83.8%	82.4%

Performance Metrics for GSTS
Determines 50% of Funding

	Minimum .8 x	PFC Target 1.0 x	Above Target 1.5 x	Far Exceeds 2.0 x
RoARC (average) (50% weighting)	110.3%	112.2%	114.9%	116.2%
Revenue Growth (25% weighting)	6.2%	7.2%	10.3%	12.8%
Efficiency Ratio (25% weighting)	73.7%	72.6%	71.4%	70.3%

Performance Metrics for ALM & Capital Markets
Determines 50% of Funding

	Minimum .8 x	PFC Target 1.0 x	Above Target 1.5 x	Far Exceeds 2.0 x
RoARC (average) (50% weighting)	36.0%	36.3%	37.2%	37.8%
Revenue Growth (25% weighting)	-27.1%	-26.4%	-24.1%	-22.1%
Efficiency Ratio (25% weighting)	41.8%	41.1%	40.5%	39.8%

Performance Metrics for Transaction Banking
Determines 50% of Funding

	Minimum .8 x	PFC Target 1.0 x	Above Target 1.5 x	Far Exceeds 2.0 x
RoARC (average) (50% weighting)	83.5%	87.8%	90.9%	92.7%
Revenue Growth (25% weighting)	-0.9%	1.8%	5.2%	7.9%
Efficiency Ratio (25% weighting)	74.2%	73.0%	71.9%	70.7%

Accelerated Vesting

In accordance with Section 7 of the Plan, the following accelerated vesting provisions shall apply to Participant's whose employment terminates during 2007.

1. If the Participant's employment is terminated by reason of retirement, death or disability pursuant to Section 7(a) on or after April 23, 2007, the Incentive Award for the Year will be the full amount of the Award to which the Participant would otherwise have been entitled and will not be reduced by the fraction set forth in Section 7(a).
2. If the Participant's employment is terminated on or after April 23, 2007, and the Participant meets all of the requirements to receive an Incentive Award as part of his or her severance benefit pursuant to Section 7(b) (without regard to the requirement that the Participant be terminated on or after August 1), then the Participant's severance benefit will be his Target Benefit without reduction by the fraction set forth in Section 7(b). In addition, if such a Participant's employment is terminated on or after October 1, 2007, the Participant may also be eligible for an Incentive Award in excess of his or her Target Award, provided that his or her CIP Pool is funded at an amount that exceeds the Target Funding. Such a Participant will receive his Target Award upon termination as set forth in Section 7(b), and will be considered for the additional Incentive Award, based upon the funding of the CIP Pool and his individual performance, on the Payment Date.

**FIRST AMENDMENT
TO THE
ABN AMRO GROUP CORPORATE INCENTIVE PLAN**

WHEREAS, the ABN AMRO Group Corporate Incentive Plan (the "Plan") was amended and restated effective as of January 1, 2007;

WHEREAS, effective August 28, 2007, sponsorship of the Plan was transferred from ABN AMRO Bank N.V. to ABN AMRO North America Holding Company;

WHEREAS, it is now desirable to amend the Plan to reflect the change in Plan sponsorship;

WHEREAS, no deferral elections were allowed with respect to any incentive awards made for the 2007 Plan Year; and

WHEREAS, ABN AMRO Bank N.V. has entered into an agreement to sell the stock of ABN AMRO North America Holding Company to Bank of America Corporation, effective October 1, 2007, and immediately prior to the consummation of such transaction ABN AMRO North America Holding Company will distribute the stock of ABN AMRO WCS Holding Company ("WCS Holding Company") to ABN AMRO Bank N.V., so that the businesses of the Excluded Employers will not be included in the sale to Bank of America Corporation.

NOW, THEREFORE, the Plan is amended as follows:

1. Effective August 28, 2007, the first Section, Purpose, shall be amended to read as follows:

The purpose of the Corporate Incentive Plan (the "Plan") is to provide an incentive to certain officers of ABN AMRO Bank N.V. and its subsidiaries and affiliates (hereinafter referred to as the "Corporation" and individually as an "Employer"). The Plan was originally established by ABN/LaSalle North America, Inc. as the Annual Management Incentive Plan, and was subsequently adopted by ABN AMRO Bank N.V., revised and renamed the Corporate Incentive Plan. Sponsorship of the Plan was transferred to ABN AMRO North America Holding Company effective as of August 28, 2007. The Plan is hereby amended and restated in its entirety, effective as of January 1, 2007."

2. Effective August 28, 2007, ABN AMRO North America Holding Company shall be the sponsor of the Plan;
3. Effective August 28, 2007, the last sentence of Section 8, Benefits, shall be amended to read as follows:

"No deferral elections are allowed with respect to any incentive awards made for the 2007 Plan Year. All Incentive Awards deferred prior to 2007, including limitations and provisions to ensure compliance with Section 409A of the Internal

Revenue Code, and all promulgations thereunder) shall be governed by the Supplemental Savings Plan.”;

4. Effective October 1, 2007, a new term “Excluded Employer” shall be included to mean “ABN AMRO WCS Holding Company, ABN AMRO Asset Management, Inc., ABN AMRO Incorporated, ABN AMRO Advisory, Inc., ABN AMRO Associates Corp., their respective subsidiaries, ABN AMRO Bank N.V., and any other branch or subsidiary of ABN AMRO Bank N.V. other than ABN AMRO North America Holding Company and its subsidiaries.”; and
5. Effective October 1, 2007, all Excluded Employers, to the extent previously participating in the Plan, shall cease participating, and the Plan shall have no further liability for benefits payable to the active employees of an Excluded Employer. The bonuses for employees who are not employed by an Excluded Employer shall be paid in accordance with the normal terms of the Plan.

In all other respects, the Plan, as heretofore amended and in effect, is hereby ratified and confirmed.

* * * *

[Signature Page Follows]

IN WITNESS WHEREOF, ABN AMRO Bank N.V., as original sponsor of the Plan, and ABN AMRO North America Holding Company, as the new sponsor of the Plan, have caused this Amendment to be executed by their duly authorized representatives this 28th day of September, 2007.

<p>ABN AMRO BANK N.V.</p>	<p>ABN AMRO NORTH AMERICA HOLDING COMPANY</p>
<p>By: <u>Managing Board Member</u> Its: <u>Managing Board Member</u></p>	<p>By: <u>President and CEO</u> Its: <u>President and CEO</u></p>
<p>By: <u>Authorized Signatory</u> Its: <u>Authorized Signatory</u></p>	

Exhibit 2

**ABN AMRO GROUP LONG TERM INCENTIVE PLAN
AMENDED AND RESTATED EFFECTIVE JANUARY 1, 2007**

1. PURPOSE

The purpose of the ABN AMRO Group Long Term Incentive Plan ("Plan") is to provide additional incentive for certain officers of LaSalle Bank Corporation ("LaSalle"), and its subsidiaries and affiliates (hereinafter referred to collectively as the "Corporation" and individually as an "Employer"). The Plan is hereby amended and restated in its entirety, effective as of January 1, 2007. Except as otherwise provided herein, all Performance Units outstanding on January 1, 2007, or thereafter granted, shall be governed by the terms of the Plan as herein amended and restated.

2. ADMINISTRATION

The Plan shall be administered by LaSalle. The authority of LaSalle to administer the Plan shall be vested in the Head of the ABN AMRO Business Unit North America ("BU NA"), or the successor to such position, and shall be exercised on his behalf by the Head of Human Resources of BU NA and BU NA Center of Expertise (CoE) for Rewards. LaSalle shall have all powers and authority necessary for the administration of the Plan, including the authority to: (a) prescribe, amend and rescind Plan rules, regulations and procedures; (b) approve financial performance goals and determine from time to time the eligibility of employees for participation in the Plan; (c) determine the number of Performance Units to be allocated to each Participant for each Performance Period; (d) make such adjustments to benefits payable under the Plan as may be necessary or appropriate to correct mistakes of fact; and (e) take any other action necessary or appropriate for the administration of the Plan. The examples in the immediately-preceding sentence are listed herein solely for purposes of illustration and not limitation.

3. ELIGIBILITY

Participants in the Plan for each Performance Period shall be those officers of the Corporation who are selected by LaSalle in its sole discretion in the manner set forth below.

For each Performance Period, each member of the BU NA Regional Management Committee or his or her delegate shall nominate the officers in his or her area who shall be eligible to participate in the Plan for that Performance Period and shall recommend the number of Performance Units to be allocated to each person so nominated. All recommendations shall be reviewed and approved by the BU NA Head of Human Resources and BU NA CoE Rewards and subject to changes, if any, requested by the Head of BU NA. Each such person eligible to participate in the Plan for a Performance Period is referred to as a "Participant." The designation of Participants for each Performance Period shall ordinarily be made within the first 90 days of the Performance Period, but in no event later than June 1 of the first year of the Performance Period. In unusual circumstances, and with the specific approval of the Head of BU NA, an employee may be designated as a Participant and allocated Performance Units for a

Performance Period after the first 90 days have elapsed. The designation of Participants, and the allocation of Performance Units, is in the sole discretion of LaSalle, and the fact that an employee is designated as a Participant for one Performance Period shall not imply any right to be designated as a Participant in any future Performance Period.

LaSalle shall, at the beginning of each Performance Period (or for Participants designated as such during the Performance Period, as soon as practicable after such designation), send a letter ("Notification Letter") to each Participant who has been allocated Performance Units for that period. The Notification Letter shall indicate for that Performance Period: (a) the number of Performance Units being allocated to that Participant; (b) the cash value of each such Performance Unit based upon the level of performance achieved; and (c) the Performance Goals applicable for such Performance Period.

4. PERFORMANCE UNITS

Performance Units shall be allocated for each Performance Period annually by LaSalle to Participants. Within the first 90 days of each Performance Period, LaSalle shall establish the cash value or range of cash values for each Performance Unit to be allocated during such Performance Period or shall establish a formula by which such cash value will be determined based upon the achievement of Performance Goals as provided in Section 5.

5. PERFORMANCE PERIODS AND GOALS

A new Performance Period shall begin on January 1 of each year, and shall last for a period of three calendar years. For avoidance of doubt, at any time there will be three overlapping Performance Periods in process, and a Participant may have been allocated Performance Units for any or all of such Performance Periods. Each Performance Period shall be treated separately for all purposes of the Plan. LaSalle may from time to time in its discretion alter the commencement, frequency or length of future Performance Periods.

During the first 90 days of each Performance Period, LaSalle shall establish one or more performance goals ("Performance Goals") consistent with the purposes of the Plan, as determined in the sole discretion of LaSalle, for that Performance Period, and if appropriate the weight to be given to each such Performance Goal for that period. The Performance Goals for the 2005, 2006 and 2007 plans, and the formula by which the Performance Units are to be valued, are as set forth in Exhibit A. LaSalle may, from time to time thereafter, make such adjustments in Performance Goals as LaSalle may determine, in its sole discretion, to be appropriate to preserve the degree of incentive in open performance periods in light of acquisitions, divestitures, accounting changes, restructuring charges, and other nonrecurring or nonoperating events.

As soon as practicable after the end of each Performance Period, LaSalle shall determine the extent to which the Performance Goals for that period were achieved, and the value of Performance Units. LaSalle shall at such other times as it deems appropriate review the status of the performance goals for open periods and may communicate such status as it

deems appropriate. If the achievement falls between two Performance Goals, the value of the Performance Units shall be interpolated.

6. VESTING

Except as provided below in this Section 6, if a Participant is actively employed by the Corporation at the end of the Performance Period, he shall be vested, at the end of such Performance Period, in his Performance Units allocated to him for that Performance Period.

If a Participant is not actively employed by the Corporation at the end of the Performance Period the number of Performance Units in which such Participant shall vest for such Performance Period shall be adjusted as provided below:

- a. If a Participant dies, becomes fully disabled as defined in the ABN AMRO Group Long Term Disability Plan, or retires under a qualified retirement plan maintained by the Corporation before the end of a Performance Period, then subject to the other provisions of this Section 6, such Participant shall be vested at the end of the Performance Period in the number of Performance Units he would have received had his employment with the Corporation continued to the end of the Performance Period, multiplied by a fraction, the numerator of which is the number of full months he was employed by the Corporation during the Performance Period, and the denominator of which is the total number of months in the Performance Period.
- b. A Participant whose employment is terminated by reason of the elimination or his or her position on or after August 1 of the first year of a Performance Period, and who otherwise meets all of the requirements for the payment of severance pay under the ABN AMRO Group Severance Plan (including without limitation execution of the Waiver and Release Agreement referred to therein) shall be vested at the end of the Performance Period in the number of Performance Units he would have received had his employment with the Corporation continued to the end of the Performance Period, multiplied by a fraction, the numerator of which is the number of full months he was employed by the Corporation during the Performance Period and the denominator of which is the total number of months in the Performance Period.

If the provisions of paragraph (a) or (b) apply to more than one Performance Period, then the fraction referred to in paragraph (a) or (b), as applicable, shall be calculated separately for each such Performance Period, based upon the number of full months he was employed during such Performance Period, and shall be multiplied by the number of Performance Units granted to the Participant for such Performance Period.

The balance of a Participant's Performance Units for any Performance Period that are not vested as provided above shall automatically be forfeited by the Participant as of the last day of that Performance Period. Any individual who voluntarily terminates prior to the end of the Performance Period shall forfeit all unvested units. LaSalle, in its discretion,

may from time to time provide for accelerated vesting. For purposes of this Section, any Participant who transfers employment to a position with an Employer, or an affiliate of LaSalle that is not an Employer, in which he is no longer eligible to participate in the Plan shall remain a Participant with respect to all outstanding Performance Units, and such Performance Units shall be fully vested at the end of the Performance Period provided that he or she is still employed by an Employer or affiliate of LaSalle at the end of the Performance Period (or shall be partially vested under paragraph (a) or (b), if applicable, if at the time of his termination of employment he was employed by an Employer or affiliate of LaSalle).

Notwithstanding the foregoing provisions of this Section 6, a Participant shall forfeit all of his Performance Units allocated to him for all Performance Periods (whether or not vested in such Performance Units) in the event that LaSalle determines

- a. that such Participant has been terminated for cause prior to the last day of the vesting period. "Cause" shall be defined as any of the following, as determined in the sole discretion of Company management:
 - (i) Violation of Company policies and procedures sufficient to warrant termination; or
 - (ii) Conviction of, or entry of a plea of guilty or nolo contendere to, a felony or a crime involving dishonesty, theft, breach of trust or sale, manufacturing or distribution of controlled substances, or immoral conduct; or
 - (iii) Failure to substantially perform the duties of the employee's position, or
- b. that such Participant is guilty of any illegal act or act of misconduct (alone or in conjunction with others) in connection with his employment by any Employer, whether or not such act occurred during any Performance Period or while he was a Participant hereunder, or
- c. that such Participant enters into competition (alone or in conjunction with others whether individually or as an employee, partner or 5% or more shareholder of or as an independent contractor with any other person or organization) with or assists or is employed by or has contracted to render personal services with any other business entity that is in competition with any financial institution that is an Employer.

7. BENEFITS.

- a. Form of Payment of Benefits. The benefits of a Participant under the Plan will be the cash value of those Performance Units in which such Participant becomes vested.
- b. Time of Payment. Except as otherwise provided for herein, payments due hereunder for vested Performance Units will be made by March 15 of the year

following the end of the Performance Period in which such Performance Units vested. Commencing with Performance Units granted for the Performance Period that ends on December 31, 2008, a Participant who is otherwise eligible to participate in the ABN AMRO Group Supplemental Savings Plan (the "SSP") may, if permitted by LaSalle, elect by an irrevocable election to defer all or a percentage of the payments due to him for Performance Units that vest during such Performance Period in accordance with the terms of the SSP. Such election must be made, in accordance with the SSP either

- (i) prior to the beginning of the Performance Period, or
- (ii) if the formula for valuing the Units for a Performance Period is established not later than the 90th day of the Performance Period, the Participant has been employed since the date on which the formula is established, and the payment for the Units for such Performance Period otherwise meets the requirements for "performance based compensation" pursuant to section 409A of the Internal Revenue Code, not later than six months prior to the end of the Performance Period.

Unless (ii) applies, a Participant who is hired after the beginning of a Performance Period shall not be eligible to defer any Performance Units granted for that Performance Period.

- c. Prior Deferrals. All Units deferred prior to 2007 shall be governed by the SSP, including limitations and provisions to ensure compliance with section 409A of the Internal Revenue Code.

8. DESIGNATION OF BENEFICIARY

In the event of the death of a Participant, all benefits to which that Participant is entitled but which are unpaid at the time of his death shall be paid to the beneficiary or beneficiaries of that Participant who are designated in writing by the Participant or in the absence of any such designation, to the Participant's estate. LaSalle shall determine in its sole discretion whether the Participant has effectively designated a beneficiary, but shall have no obligation to solicit beneficiary designations, and in any event LaSalle shall have no obligation to any other person as a result of any payment made to a person whom LaSalle has determined in good faith to be the Participant's beneficiary. Performance Units for Performance Periods that have not ended at the time of the Participant's death shall be paid at the same time and in the same manner as payments to other Participants, and any election the Participant has made to defer such payments shall be revoked by his or her death. Payment for Performance Units for Performance Periods that have ended and for which the Participant had previously elected to defer shall be paid in accordance with the terms and conditions of the SSP.

9. AMENDMENT OR TERMINATION OF PLAN

LaSalle, or its successor, may terminate, amend or modify this Plan at any time and from time to time; provided however, any such termination, amendment or modification, or

any administrative action may not divest any Participant of any of his benefits under this Plan as of the date of such termination, amendment or modification.

10. **GENERAL PROVISIONS**

- a. **No Right of Continued Employment.** Nothing contained in the Plan shall give any Participant the right to be retained in the employment of any Employer or affect the right of any Employer to dismiss any Participant.
- b. **No Right to Continued Payments.** The allocation of any Performance Units, the vesting therein or the payment of any Plan benefits for any Performance Period shall not guarantee a Participant the right to receive any such allocation, vesting or payment for any subsequent Performance Period.
- c. **No Right of Transfer.** The interests of persons entitled to benefits under the Plan are not subject to their debt; or other obligations and except for tax withholding requirements or as otherwise specifically provided herein, may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered.
- d. **Withholding for Taxes.** Each Employer shall have the right to deduct from all amounts paid under this Plan any taxes required by federal, state or local law to be withheld with respect to such payments.
- e. **Special Compensation.** Except as otherwise provided by law, or as explicitly provided in such plan or agreement, benefits received under the Plan shall not be included or taken into account in determining benefits under pension, retirement, profit sharing, group insurance, or any other benefit plan or employment agreement maintained or entered into by the Corporation; provided that effective January 1, 2007, such benefits shall be considered compensation for purposes of the ABN AMRO Group 401(k) Retirement Savings Plan. Neither the Corporation nor LaSalle guarantee in any way the deferral of tax liability if a Participant defers the payment of Plan benefits. To the extent that any such plan or agreement refers to Units that are paid or payable for any year, or that vest in any year, for purposes of calculating the amount of any benefit or entitlement, such plan or agreement shall be construed as referring only to the Units granted for the Performance Period that ends on the last day of such year and not to any other Units, regardless of the time of actual payment or vesting of such Units or any other Units.
- f. **Acceleration or Deferral of Payments; Effect of Section 409A.** With respect to all Units granted on or after January 1, 2005, the Plan shall be construed and administered in accordance with the requirements of Section 409A of the Internal Revenue Code, anything else contained herein to the contrary notwithstanding. In no event shall any payment to any Participant with respect to any such Units be deferred to any time later, or accelerated to any time earlier, than as specified in Section 7, whether by exercise of LaSalle's discretion, a separate agreement between the Corporation and a Participant. Notwithstanding the foregoing,

LaSalle may enter into agreements prior to December 31, 2007, with individual Participants providing for an acceleration of the payment for their Units upon the occurrence either of a change of control of LaSalle, or certain terminations of employment prior to a change of control, provided that

- (i) if such acceleration occurs upon a change of control that occurs while the Participant is still employed and such change of control occurs after December 31, 2007, the change of control satisfies the definition of a "change of control event" as defined in the regulations under section 409A,
- (ii) if such acceleration occurs upon a termination of employment prior to the change of control, the termination constitutes a "separation from service" as defined in the SSP and, if the Participant is a "key employee" as defined in the SSP the payment will be made not earlier than six months after the date of termination, and
- (iii) in any event, no amount payable pursuant to any such agreement that would not otherwise have been payable during 2007 shall be paid prior to January 1, 2008.

g. Law to Govern. All questions pertaining to the construction, regulation, validity and effect of the provisions of the plan shall be determined in accordance with the laws of the State of Illinois, to the extent not preempted by applicable Federal law.

h. Funding of Benefits. Benefits payable hereunder to or on account of any Participant shall be paid directly by the Corporation from its general assets. The Corporation shall not be required to segregate on its books or otherwise set aside any amount to be used for the payment of benefits under this Plan.

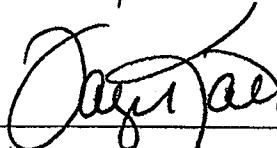
i. Interpretation. LaSalle shall have the sole and complete authority to interpret the provisions of and decide all disputes arising under the Plan, which interpretations and decisions shall be final and binding on all parties having any interests arising under or by virtue of the Plan.

j. Litigation. If any Participant, former Participant or beneficiary shall bring a suit or proceeding against LaSalle or the Corporation, or if any dispute shall arise as to the person or persons to whom payment or delivery of any funds shall be made by the Corporation, the costs (including attorneys' fees) to the Corporation of defending the action, where the result is adverse to the complainant, or pursuant to the authorization of the court or other forum in which the suit or proceeding is brought, shall be charged against the Plan benefits of the applicable Participant, former Participant or beneficiary and only the excess of such Plan benefits, if any, over the amount of such costs shall be payable by the Corporation.

IN WITNESS WHEREOF, the undersigned has caused this Amended and Restated Plan to be executed as of the 27 day of June 2007.

ABN AMRO BANK N.V.

By: 

By: 


Annetta van der Werff

EXHIBIT A

PERFORMANCE GOALS AND PERFORMANCE UNIT VALUATION FORMULAE
FOR PERFORMANCE PERIODS BEGINNING IN 2005, 2006 AND 2007

The following sets forth the Performance Goals and the formula to be used to value Performance Units for the Performance Periods beginning in 2005, 2006, and 2007. For each year:

1. The maximum value for Performance Units is \$200 per Unit.
2. If the achievement falls between two Performance Goals, the value of the Units shall be interpolated.
3. LaSalle may, from time to time, make such adjustments in Performance Goals as LaSalle may determine, in its sole discretion, to be appropriate to preserve the degree of incentive in open Performance Periods in light of acquisitions, divestitures, accounting changes, restructuring charges, and other nonrecurring or nonoperating events.

For the Performance Period commencing January 1, 2007, and ending December 31, 2009, Performance Units will be valued based upon LaSalle's average Return on Assigned Risk Capital ("RoARC") over the Performance Period, which aligns to BU NA's Performance Contract, as follows.

RoARC	Unit Value
22.5%	\$200
21.0%	\$150
19.5%	\$100
18.0%	\$50
17.25%	\$25
Below 17.25%	\$ -

For the Performance Period commencing January 1, 2006, and ending December 31, 2008, Performance Units will be valued based upon LaSalle's average Return on Economic Capital ("RoEC") over the Performance Period. The Performance Goals have been revised to reflect the reorganization of BU NA, as follows.

RoEC	Unit Value
26.5%	\$200
25.0%	\$150
23.5%	\$100
22.0%	\$50
21.25%	\$25
Below 21.25%	\$ -

For the Performance Period commencing January 1, 2005, and ending December 31, 2007, Performance Units will be valued based upon LaSalle's average Return on Economic Capital ("RoEC") over the Performance Period. The Performance Goals have been revised to reflect the reorganization of BU NA, as follows.

RoEC	Unit Value
24.5%	\$200
23.0%	\$150
21.5%	\$100
20.0%	\$50
19.25%	\$25
Below 19.25%	\$ -

**AMENDMENT TO
ABN AMRO GROUP LONG TERM INCENTIVE PLAN**

Instrument of Amendment

THIS INSTRUMENT is executed by the Chief Administrative Officer of BANK OF AMERICA CORPORATION, a Delaware corporation with its principal office and place of business in Charlotte, North Carolina (the "Company"), on behalf of ABN AMRO North America Holding Company ("AANA").

Statement of Purpose

AANA previously adopted the ABN AMRO Group Long Term Incentive Plan (the "Plan") for the benefit of eligible employees and reserved the right to amend the Plan from time to time. Effective as of the consummation of the transactions contemplated by the Purchase and Sale Agreement dated April 22, 2007, as amended, by and between ABN AMRO Bank N.V. and the Company, the Company acquired AANA on October 1, 2007. Pursuant to applicable resolutions, the Company's Chief Administrative Officer currently has the right to execute Plan amendments on behalf of AANA. By this Instrument, AANA is amending the Plan to (1) set the value of outstanding Performance Units, (2) provide a new payment rule for payments made following a termination of employment, and (3) freeze the Plan effective December 31, 2007, as to the inception of new Performance Periods.

NOW, THEREFORE, AANA hereby amends the Plan effective as of October 1, 2007:

1. Section 4 of the Plan shall be amended by adding the following new sentence at the end thereof:

"Notwithstanding the foregoing, the value of all Performance Units outstanding on October 1, 2007, shall be \$200 per unit."

2. Section 5 of the Plan shall be amended by adding the following new paragraph at the end thereof:

"Notwithstanding any other provisions of the Plan to the contrary, no new Performance Period shall begin on or after January 1, 2008. For the avoidance of doubt, (1) the Performance Period which began on January 1, 2007, shall be the final Performance Period under the Plan, (2) payments due hereunder for vested Performance Units allocated for the Performance Periods which began in 2005, 2006 and 2007 shall be made

in 2008, 2009 and 2010, respectively, pursuant to Plan terms, and (3) no additional Performance Units shall be allocated hereunder."

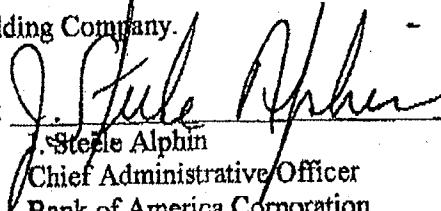
3. Subsection 7.b. of the Plan shall be amended by adding the following new paragraph at the end thereof:

"Notwithstanding any other provisions of the Plan to the contrary, payment of vested Performance Units to a Participant who has terminated employment shall occur on the earlier of (x) the date specified above in the first sentence of this subsection 7.b. and (y) the first anniversary of the Participant's date of termination, unless such Performance Units are otherwise forfeited pursuant to Section 6 of the Plan above."

4. Exhibit A of the Plan shall be amended by adding the following new paragraph at the end thereof:

"Notwithstanding the foregoing, the value of all Performance Units outstanding on October 1, 2007, shall be \$200 per unit."

IN WITNESS WHEREOF, the Chief Administrative Officer of Bank of America Corporation hereby executes this Instrument on the 19th day of December, 2007 on behalf of ABN AMRO North America Holding Company.

By: 

J. Steele Alphin
Chief Administrative Officer
Bank of America Corporation

Exhibit 3

**ABN AMRO GROUP
SEVERANCE PAY PLAN**

PLAN DOCUMENT

**(Amended and Restated
effective April 17, 2007)**

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**ABN AMRO GROUP
SEVERANCE PAY PLAN**

ESTABLISHMENT OF THE PLAN

ABN AMRO Bank N.V. (hereinafter the "Company") hereby adopts the ABN AMRO GROUP SEVERANCE PAY PLAN (hereinafter the "Plan"), as amended and restated effective March 1, 2007, for the benefit of eligible employees of the Company and its United States subsidiaries and affiliates. Wherever the context requires, the term "Company" as used herein shall refer to the subsidiary or affiliate that is the employer of an eligible employee.

The Plan is an unfunded welfare benefit plan for purposes of the Employee Retirement Income Security Act of 1974, as amended (hereinafter "ERISA"). The Plan supersedes any prior formal or informal severance plans, programs or policies of the Company covering eligible employees.

The benefits provided under the Plan include a specified number of weeks of continued payment of the eligible employee's pay following termination of employment, referred to herein as "severance pay", and certain other welfare and fringe benefits, referred to herein as "severance benefits." The term "severance" includes both severance pay and severance benefits.

This restatement of the Plan supersedes the Plan effective January 1, 2007, as previously restated effective March 19, 2007. The amendments made by this restatement of the Plan are generally intended as clarifications and are effective as of the original effective date of the Plan; provided, however, that nothing contained in this restatement shall be construed to require any change to an offer of severance made prior to the date on which this restatement is executed.

PURPOSES OF THE PLAN

The purposes of the Plan are

- (a) to provide an eligible employee with severance for a specified period of time in the event that his/her employment is involuntarily terminated by the Company pursuant to a reduction in force or similar program (a "RIF") as hereinafter described; and
- (b) to provide a mechanism for the payment of severance to individual employees whose employment is involuntarily terminated by the Company other than pursuant to a RIF and other than for cause, in the sole discretion of the Company.

REDUCTIONS IN FORCE

From time to time, the Company, in its discretion, may decide to provide severance for employees in a specified group, class or business unit pursuant to a reduction in force, branch or division closing or restructuring, or similar program. Each such program shall be referred to in this Plan as a "RIF." Each such RIF shall be identified in a separate written appendix to this Plan, which shall specify the group or class of employees to whom the RIF will apply (which shall be defined in accordance with the definition of "decisional unit" as set forth in EEOC regulations 29 CFR §1625.22), the period during which the RIF will be in effect, the eligibility criteria for employees affected by the RIF, and any difference between the standard severance provided herein and the severance to be provided pursuant to the RIF. Each such RIF shall be administered as a separate program within this Plan, and in the event of any differences between the RIF program as set forth in the applicable appendix and this Plan, the terms of the RIF program shall control. Except as otherwise determined by the Company, any employee whose position is eliminated shall be treated as having been terminated pursuant to a RIF.

ELIGIBLE EMPLOYEES

The Plan is applicable to each full time and part time United States based employee of the Company who is part of a class or group identified pursuant to a RIF as described in an Appendix to this Plan. From time to time the Company may in its sole discretion offer severance under this Plan (which may vary from the terms set forth below) to a full or part time United States based employee whose employment is involuntarily terminated other than for cause and who is not part of a RIF, but shall in no event be required to do so. No person shall be considered an eligible employee unless he or she has received a written notice specifying the severance he/she is eligible to receive and a Waiver and Release Agreement.

ELIGIBILITY REQUIREMENTS

In order for an eligible employee to be eligible to receive Plan severance, an eligible employee must meet the following eligibility requirements: (i) he/she must receive a written notice specifying the severance for which he/she is eligible (ii) he/she must remain in the employ of the Company through the date of termination of employment designated in writing by the Company, (iii) through the date of termination of employment, he/she must fulfill the normal responsibilities of his/her position, including meeting regular attendance, workload and other standards of the Company, and (iv) he/she must submit the signed Waiver and Release Agreement required by the Plan by the time specified in the notice of severance eligibility and (v) he/she must not revoke the signed Waiver and Release Agreement within seven days after executing it.

CONDITIONS OF INELIGIBILITY

An employee of the Company shall not be considered an eligible employee nor be eligible for severance under the Plan if:

- (a) the employee is not or ceases to be an eligible employee as defined in the Plan;
- (b) the employee's employment with the Company terminates prior to the date of termination of employment designated in writing by the Company by reason of employee's retirement, resignation, failure to report for work, death or discharge for cause, as determined in the sole discretion of the Company;
- (c) the employee's employment with the Company terminates under any other circumstances other than meeting the eligibility requirements of the Plan;
- (d) the employee is entitled to a benefit from a long term disability benefit plan sponsored by the Company;
- (e) the employee is employed in a position or a Company division, department, operational unit, function or facility which is off-shored or outsourced to a vendor, or sold, leased or otherwise divested and the employee is offered comparable employment by the vendor or successor entity (as determined in the sole discretion of the Company);
- (f) the employee is a party to an employment, separation, or other agreement providing for payments in the nature of severance or separation pay, unless such agreement expressly provides that such payments are in addition to severance under this Plan;
- (g) the employee's employment with the Company is terminated after the employee is offered comparable employment by the Company, as determined by the Company in its sole discretion, and the employee rejects such offer; or
- (h) the Plan is terminated.

The foregoing list of conditions is intended to be illustrative and may not be all inclusive; the Plan Administrator will determine in the Plan Administrator's sole discretion whether an employee or other person is eligible for severance under the Plan.

For all purposes under the Plan, "cause" includes, but is not limited to, termination of the employee's employment because of (a) negligence or misconduct by the employee in the performance of his/her duties for the Company for activities including, but not limited to, insubordination, misappropriation or misuse of Company information, abusive or inappropriate behavior towards coworkers or customers, (b) violation of the Company's drug and alcohol policy, (c) the employee's conviction for or admission of a felony offense, or the employee's indictment for a criminal offense involving or relating to the business of the Company, (d) the employee's act of fraud, theft, dishonesty, or embezzlement with respect to the Company, or (e) the employee's misconduct which, in the judgment of the Company, brings the reputation of the Company into disrepute or causes the employee to be unable to perform his/her duties.

For all purposes of the Plan, an offer of "comparable employment" means (i) the employee receives an offer of employment by a vendor or successor employer with a regular weekly base salary compensation rate or regular hourly base compensation rate, as applicable, which is equal to or greater than such applicable rate with the Company on the date he/she receives such offer of employment, or (ii) the employee receives an offer of continuing employment by the Company (A) with a regular weekly base salary compensation rate or regular hourly base compensation rate, as applicable, which is equal to or greater than such applicable rate with the Company on the date he/she receives such offer and (B) the employee's commuting distance to such position with the Company is within 35 miles from the current location, or such other commuting distance as determined from time to time by the Company.

SEVERANCE PAY AND SEVERANCE BENEFITS

If an eligible employee satisfies the eligibility requirements, his/her severance will be based upon his/her years of service, the amount of his/her pay and his/her employment classification.

In exchange for providing the Company with an enforceable Waiver and Release Agreement in a form acceptable to the Company, each eligible employee is eligible to receive as Plan severance the following (except as otherwise provided in an Appendix to the Plan with respect to a RIF, or in an employee's written notice of severance):

(a) **Severance Pay:**

Severance pay shall be determined in accordance with the following table:

Eligible Employee's Employment Classification	Amount of Severance Pay
Executive Vice President/Corporate Managing Director or equivalent position	<p>Twenty-six (26) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of sixty-four (64) weeks of pay</p> <p>Eligible to receive bonus as described below</p>
Group Senior Vice President/Senior Vice President/Executive Director / Managing Director or equivalent position	<p>Twenty-six (26) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of fifty-two (52) weeks of pay</p> <p>Eligible to receive bonus as described below</p>
Vice President and First Vice President/Corporate Director/ Director or equivalent position	<p>Sixteen (16) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of fifty-two (52) weeks</p>

	of pay
	Eligible to receive bonus as described below
Officer/ Associate and Assistant Vice President or equivalent position	Twelve (12) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of fifty-two (52) weeks of pay
	Eligible to receive bonus as described below
Exempt (non Officer) with at least One Year of Service	Six (6) weeks of pay plus one (1) week of pay for each year of service, with a minimum total of eight (8) weeks of pay and a maximum total of fifty-two (52) weeks of pay
Nonexempt with at least One Year of Service	Four (4) weeks of pay plus one (1) week of pay for each year of service, with a minimum total of eight (8) weeks of pay and a maximum total of fifty-two (52) weeks of pay
Exempt (non Officer) Or Nonexempt With Less Than One Year of Service	Four (4) weeks of pay

In the case of an employee whose position is not listed above, the amount of severance pay will be determined by the Company in its discretion and set forth in the employee's notice of eligibility for severance.

In addition to the number of weeks of pay described above, the severance pay of an eligible employee at the Officer/Associate and Assistant Vice President level and above, and who participates in an annual bonus and/or long-term incentive plan that does not ordinarily provide any benefit for the year in which the employee terminates, may include a proportionate share of the bonus and/or long-term incentive payment for the year in which the termination occurs. Such proportionate share shall be based on the number of months in the year of termination completed prior to the date of termination, and shall be payable only if the eligible employee's termination occurs after August 1 of the year. An eligible employee who is terminated before receiving a bonus for the prior year may be eligible for a bonus for the prior year at the Company's discretion, depending on the terms of the bonus plan, but such bonus will not be severance pay and will not be dependent upon the eligible employee's execution of the Waiver and Release Agreement. Any decision to include bonus and/or long term incentive payouts will be determined by the Company based on the employee's performance. The amount of the

bonus and/or long term incentive payment (prior to proration) shall normally be determined as follows, subject to the Company's discretion to adjust or eliminate bonuses in individual cases:

- (a) If the eligible employee participates in the Corporate Incentive Plan ("CIP"), the payment shall be based on the eligible employee's assigned target percentage for the year, and shall be paid as soon as administratively feasible following the termination date.
- (b) If the eligible employee participates in an annual bonus plan other than the CIP in which bonuses are based on a formula, the payment will be based on the average of the eligible employee's annual bonuses during the three prior years (or, if fewer, the number of years the eligible employee was eligible to participate in the bonus plan), and shall be paid as soon as administratively feasible following the termination date.
- (c) If the eligible employee participates in a discretionary annual bonus plan, the payment will be based on the eligible employee's annual bonus in the immediately prior year, and shall be paid as soon as administratively feasible following the termination date. If the eligible employee was not eligible for a discretionary bonus in the prior year, the eligible employee shall not be eligible for a pro rated share of the bonus in the year of termination.
- (d) If the eligible employee participates in the Long Term Incentive Plan ("LTIP"), the eligible employee shall vest in a proportionate number of the units that would otherwise have vested on the last day of the year of termination. The value of the units, and the time of payment, shall be as determined under the LTIP.
- (e) In the case of any annual bonus or long term incentive plan not described above, the amount of the payment shall be determined by the Plan Administrator applying principals analogous to those set forth above, and the Plan Administrator's determination shall be final and binding.

Anything else contained herein to the contrary notwithstanding, except as otherwise provided in the following sentence, in no event shall the total amount of severance pay payable to any eligible employee exceed two times the lesser of (i) the employee's annual rate of pay in the calendar year immediately preceding the year in which his/her employment was terminated (adjusted by any increase in base compensation that would have been expected to continue indefinitely had the employee's employment not been terminated) or (ii) the maximum amount of compensation that could be taken into account in a tax qualified retirement

plan pursuant to Section 401(a)(17) of the Internal Revenue Code in the year in which the employment is terminated (the "Maximum Benefit").

In the case of an officer whose total severance pay would otherwise exceed the Maximum Benefit, each payment of severance pay shall constitute a separate "payment" for purposes of Section 409A of the Internal Revenue Code, and the aggregate amount of payments paid to the employee after March 15 of the year following the year of termination of employment, but before the date that is six months after the termination of employment, shall not exceed the Maximum Benefit. To the extent the amount of such benefits would otherwise exceed the Maximum Benefit, the payments shall be reduced, in reverse order of payment, and the amount of such reductions shall be paid to the employee, in a lump sum, six months after the termination of employment.

For all purposes of the Plan, an eligible employee's "**years of service**" shall be determined from the eligible employee's hire date (or adjusted hire date, if any) in accordance with the Company's personnel records. Except as otherwise determined by the Company, an eligible employee whose termination date occurs more than six months from the most recent anniversary of his hire date (or adjusted hire date) shall be credited with an additional full year of service. An employee's years of service shall not include any period that was taken into account in determining the severance pay, under this Plan or any other severance plan of the Company, that was received by the employee on a previous termination of employment (and not required to be repaid by reason of reemployment), and the Company may make other adjustments to severance pay to reflect severance pay previously received.

For all purposes of the Plan, a "**week of pay**" (i) for a full-time eligible employee shall be determined by using for an Officer level or exempt eligible employee the regular weekly base salary compensation rate on his/her date of termination of employment with the Company and for a nonexempt eligible employee the regular hourly base compensation rate multiplied by his/her regularly scheduled number of hours per week on his/her date of termination of employment with the Company, and (ii) for a part-time eligible employee shall be determined on a prorated basis based upon his/her actual number of hours worked per week in the previous year of employment with the Company.

For all purposes of the Plan, an eligible employee's employment classification as an "**exempt**" or "**nonexempt**" employee shall be determined by the Plan Administrator in accordance with the definition of such terms under the Fair Labor Standards Act, as amended.

(b) **Severance Benefits:**

(i) Medical, dental and vision benefits coverage continuation:

If an eligible employee shall elect to exercise his/her applicable COBRA continuation rights to continue his/her Company sponsored medical, dental and vision benefits, such medical, dental and vision benefits shall be provided at the active employee monthly contribution cost to the eligible employee for the number of weeks equal to which he/she is entitled to receive payment of his/her severance pay. Thereafter, the eligible employee shall be required to pay the full applicable COBRA premium, including the COBRA administration fee..

All of the terms and conditions of the Company sponsored medical, dental and vision benefit plans, as amended from time to time, shall be applicable to an eligible employee (and his/her eligible dependents, if applicable) participating in any form of continuation coverage under the Company sponsored medical and dental benefit plans.

(ii) Career Transition Assistance:

Each full-time eligible employee shall be eligible to receive career transition assistance services at such level of services as determined by the Company. Career transition assistance services shall be provided by a career transition assistance firm selected and paid for by the Company. An eligible employee must begin the available career transition assistance services within sixty (60) days following return of the signed Waiver and Release Agreement.

The consideration for the voluntary Waiver and Release Agreement shall be the severance which the eligible employee would otherwise not be eligible to receive.

The amounts of severance pay and severance benefits set forth above are intended as guidelines. The Company shall have the complete discretion (which may be exercised in individual cases and need not be exercised consistently) to alter the amount or type of severance pay or severance benefits received by any employee. In all cases, the amount and type of severance pay and severance benefits stated in each employee's notice of severance shall govern, and no employee shall have any right to any severance pay or severance benefits in addition to the amounts set forth in his notice of severance.

PAYMENT OF SEVERANCE PAY

Severance pay will be paid in installments in accordance with the Company's regular payroll payment schedule as soon as practicable following the eligible employee's date of termination of employment (except for the proportionate share of annual bonuses and long-term incentives which shall be paid as described above), however any severance will be paid only after the seven (7) day revocation period for a signed Waiver and Release Agreement has passed. The Company reserves the right however, in its sole discretion, to pay severance pay (other than the amount of severance pay that exceeds

the Maximum Benefit) in a single lump sum payment. All legally required taxes and any sums owed the Company shall be deducted from Plan severance payments. In no event shall any amount of severance pay be paid after the last day of the second calendar year ending after the date of termination of employment.

In the event that an eligible employee who is receiving payment of severance pay under the Plan either is reemployed by the Company or an affiliate, the payment of severance under the Plan shall cease as of the date his/her reemployment begins. In the event an eligible employee has received his/her severance pay in a single lump sum payment and is then reemployed by the Company or an affiliate during a period of time during which he/she would have been receiving severance pay if paid to him/her in installments, he/she shall be required to repay to the Company that portion of the single lump sum payment attributable to the period of time from the date his/her reemployment begins to the date he/she would have received his/her last installment payment of severance pay.

WAIVER AND RELEASE AGREEMENT

In order to receive the severance available under the Plan, an eligible employee must submit a signed Waiver and Release Agreement form to the Plan Administrator on or within forty five (45) days after his/her date of termination of employment. In the case of an employee who is offered severance other than as part of a RIF, the employee may be required to submit the signed Waiver and Release Agreement within a shorter period of time, but in no event less than twenty-one (21) days after his/her termination of employment. A form of Waiver and Release Agreement, which shall be modified as required, is attached hereto as Attachment I. An eligible employee may revoke his/her signed Waiver and Release Agreement within seven (7) days of his/her signing the Waiver and Release Agreement.

Any such revocation must be made in writing and must be received by the Plan Administrator within such seven (7) day period. An eligible employee who timely revokes his/her Waiver and Release Agreement shall not be eligible to receive any severance under the Plan. An eligible employee who timely submits a signed Waiver and Release Agreement form and who does not exercise his/her right of revocation shall be eligible to receive severance under the Plan.

Eligible employees shall be advised to contact their personal attorney at their own expense to review the Waiver and Release Agreement form if they so desire.

PLAN ADMINISTRATION

ABN AMRO Bank N.V. shall serve as the "Plan Administrator" of the Plan and the "named fiduciary" within the meaning of such terms as defined in ERISA. The Plan Administrator shall have the discretionary authority to determine eligibility for Plan severance and to construe the terms of the Plan, including the making of factual determinations. The decisions of the Plan Administrator shall be final and conclusive with respect to all questions concerning the administration of this Plan. The Plan

Administrator will determine in the Plan Administrator's sole discretion whether an employee is an eligible employee and is eligible for severance under the Plan. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

The authority and duties of the Plan Administrator shall be performed on behalf of the Plan Administrator by the Company's Head of Human Resources/North America, or persons acting under his or her authority and supervision. The Plan Administrator may delegate to other persons responsibilities for performing certain of the duties of the Plan Administrator under the terms of this Plan and may seek such expert advice as the Plan Administrator deems reasonably necessary with respect to the Plan. The Plan Administrator shall be entitled to rely upon the information and advice furnished by such delegatees and experts, unless actually knowing such information and advice to be inaccurate or unlawful. The Plan Administrator shall establish and maintain a reasonable claims procedure, including a procedure for appeal of denied claims. In no event shall an eligible employee or any other person be entitled to challenge a decision of the Plan Administrator in court or in any other administrative proceeding unless and until the claim and appeals procedures established under this Plan have been complied with and exhausted.

In the event of a RIF or other group termination, as determined in the sole discretion of the Plan Administrator, the Plan Administrator shall furnish affected eligible employees with such additional information as may be required by law.

AMENDMENT/TERMINATION/VESTING

Eligible employees do not have any vested right to severance under the Plan and the Company reserves the right in its sole discretion to amend or terminate the Plan at any time in writing signed by any Executive Vice President or higher titled officer of the Company, provided, however, that no amendment nor termination shall reduce severance which have commenced being provided to an eligible employee.

NO ASSIGNMENT

Severance payable under the Plan shall not be subject to anticipation, alienation, pledge, sale, transfer, assignment, garnishment, attachment, execution, encumbrance, levy, lien, or charge, and any attempt to cause such severance to be so subjected shall not be recognized, except to the extent required by law. However, severance pay may be offset by any amounts owed by the eligible employee to the Company.

RECOVERY OF PAYMENTS MADE BY MISTAKE

An eligible employee shall be required to return to the Company any severance payment, or portion thereof, made by a mistake of fact or law. Any amount paid to an eligible employee by mistake shall be held by such employee in a constructive trust for the benefit of the Company.

CONFIDENTIAL INFORMATION/COOPERATION

Eligible employees may have had access to trade secrets and other confidential and proprietary information (hereinafter "Confidential Information") with regard to the business of the Company. Recognizing that the disclosure or improper use of such Confidential Information or the breach of any restrictive covenant agreement(s) covering the eligible employee will cause serious and irreparable injury to the Company, eligible employees with such access and/or restrictive covenant agreement(s) acknowledge that (i) they will not at any time, directly or indirectly, disclose Confidential Information to any third party or otherwise use such Confidential Information for their own benefit or the benefit of others (ii) they will not breach such restrictive covenant agreement(s), and (iii) payment of severance under the Plan shall cease if an eligible employee discloses or improperly uses such Confidential Information.

Each eligible employee shall cooperate with the Company and its legal counsel in connection with any current or future investigation, regulatory matter or litigation relating to any matter to which the eligible employee was involved or of which the eligible employee has knowledge or which occurred during the eligible employee's employment. Such assistance shall include, but not be limited to, depositions and testimony and shall continue until such matters are resolved. In addition, an eligible employee shall not in any way disparage the Company and its affiliates nor any person associated with the Company and its affiliates to any person, corporation, or other entity.

REPRESENTATIONS CONTRARY TO THE PLAN

No employee, officer, or director of the Company has the authority to alter, vary, or modify the terms of the Plan except by means of an authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan and its written amendments shall be binding upon the Plan, the Plan Administrator, or the Company.

NO EMPLOYMENT RIGHTS

This Plan shall not confer employment rights upon any person. No person shall be entitled, by virtue of the Plan, to remain in the employ of the Company and nothing in the Plan shall restrict the right of the Company to terminate the employment of any eligible employee or other person at any time.

PLAN FUNDING

No eligible employee shall acquire by reason of the Plan any right in or title to any assets, funds, or property of the Company. Any severance which becomes payable under the Plan is an unfunded obligation and shall be paid from the general assets of the Company. No employee, officer, director or agent of the Company personally guarantees in any manner the payment of severance. The Company may, in its discretion, establish a separate fund or trust for the payment of benefits under the Plan, but no eligible employee shall have the right to require the Company to establish any

such fund or trust, or any interest in funds set aside for the payment of benefits other than that of a general unsecured creditor.

APPLICABLE LAW

This Plan shall be governed and construed in accordance with ERISA and in the event that any reference shall be made to State law, the laws of the State of Illinois shall apply, without regard to its conflicts of law provisions.

SEVERABILITY

If any provision of the Plan is found, held or deemed by a court of competent jurisdiction to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan shall continue in full force and effect.

PLAN YEAR

The ERISA plan year of this Plan shall be the twelve month period commencing on January 1 of each year.

MANDATED PAYMENTS

The severance available under the Plan are the maximum made available by the Company in the event of involuntary termination of employment. To the extent that a federal, State or local law may mandate the Company to make a payment to an eligible employee because of involuntary termination of employment or in accordance with a plant closing law, the severance available under the Plan may, in the sole discretion of the Plan Administrator, be reduced by the amount of such mandated payment.

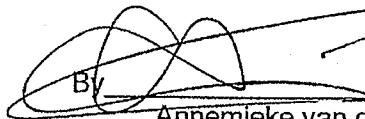
MISCELLANEOUS PROVISIONS

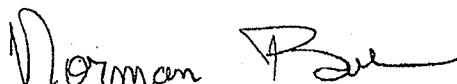
In order for an eligible employee to receive and retain severance under the Plan, (i) he/she shall be required to return all Company property (including, but not limited to, Confidential Information, client lists, keys, credit cards, access cards, personal digital assistants, mobile telephones, documents and records, identification cards, equipment, laptop computers, software, and pagers), (ii) complete and submit all expense reimbursement requests, and (iii) repay any outstanding bills, advances, debts, or amounts due to the Company and clear any corporate credit card charges as of his/her date of termination of employment with the Company.

All pay and other benefits (other than severance) payable to an eligible employee as of his/her date of termination of employment with the Company according to the established policies, plans, and procedures of the Company shall be paid in accordance with the terms of those established policies, plans, and procedures. In addition, any benefit continuation or conversion rights which an eligible employee has as of his/her date of termination of employment with the Company according to the established policies, plans, and procedures of the Company shall be made available to him/her.

IN WITNESS WHEREOF, ABN AMRO Bank N.V. has caused this amendment and restatement of the Plan to be executed on the date set forth below.

ABN AMRO BANK N.V.


By Annemieke van der Werff

By 
Norman R. Bobins

Date April 17, 2007

ATTACHMENT I

**ABN AMRO GROUP
SEVERANCE PAY PLAN**

WAIVER AND RELEASE AGREEMENT

(1) **General Release.** In consideration for the severance pay and severance benefits to be provided to me under the terms of the **ABN AMRO GROUP SEVERANCE PAY PLAN**, I, on behalf of myself and my heirs, executors, administrators, attorneys and assigns, hereby waive, release and forever discharge **ABN AMRO BANK, N.V.** (hereinafter referred to as the "Company") together with the Company's parent, subsidiaries, divisions and affiliates, whether direct or indirect, its and their joint ventures and joint venturers (including their respective directors, officers, employees, shareholders, partners and agents, past, present, and future), and each of its and their respective successors and assigns (hereinafter collectively referred to as "Releasees"), from any and all known or unknown actions, causes of action, claims or liabilities of any kind which have been or could be asserted against the Releasees arising out of or related to my employment with and/or separation from employment with the Company and/or any of the other Releasees up to and including the date of this Waiver and Release Agreement, including but not limited to:

- (a) claims, actions, causes of action or liabilities arising under Title VII of the Civil Rights Act, as amended, the Age Discrimination in Employment Act, as amended ("ADEA"), the Employee Retirement Income Security Act, as amended, the Rehabilitation Act, as amended, the Americans with Disabilities Act, as amended, the Family and Medical Leave Act, as amended, Worker Adjustment and Retraining Notification Act, as amended, [ADD SPECIFIC STATE LAWS AS APPLICABLE FROM ATTACHMENT II] and/or any other federal, state, municipal, or local employment discrimination statutes or ordinances (including, but not limited to, claims based on age, sex, attainment of benefit plan rights, race, religion, national origin, marital status, sexual orientation, ancestry, harassment, parental status, handicap, disability, retaliation, and veteran status); and/or
- (b) claims, actions, causes of action or liabilities arising under any other federal, state, municipal, or local statute, law, ordinance or regulation; and/or
- (c) any other claim whatsoever including, but not limited to, claims for pay/wages/commissions, severance pay, claims for bonus, claims for expense reimbursement, claims based upon breach of contract, wrongful termination, defamation, intentional infliction of emotional distress, tort, personal injury, invasion of privacy, violation of public policy, negligence

and/or any other common law, statutory, regulatory or other claim whatsoever arising out of or relating to my employment with and/or separation from employment with the Company and/or any of the other Releasees,

but excluding the filing of an administrative charge of discrimination, any claims which I may make under state workers' compensation or unemployment laws, and/or any claims which by law I cannot waive.

(2) **Covenant Not To Sue.** In addition to and apart from the General Release contained in paragraph 1 above, I also agree never to sue any of the Releasees or become party to a lawsuit on the basis of any claim of any type whatsoever arising out of or related to my employment with and/or separation from employment with the Company and/or any of the other Releasees, except I may bring a lawsuit to challenge this Waiver and Release Agreement under the ADEA.

(3) **Consequences Of Breach Of Covenant Not To Sue.** I further acknowledge and agree that if I breach the provisions of paragraph (2) above, then (a) the Company (and/or any of the other Releasees) shall be entitled to apply for and receive an injunction to restrain any violation of paragraph (2) above, (b) the Company (and/or any of the other Releasees) shall not be obligated to continue payment of the severance pay and availability of severance benefits to me, (c) I shall be obligated to pay to the Company (and/or any of the other Releasees) its costs and expenses in enforcing this Waiver and Release Agreement and defending against such lawsuit (including court costs, expenses and reasonable legal fees), and (d) as an alternative to (c), at the Company's (and/or any of the other Releasees) option, I shall be obligated upon demand to repay to the Company (and/or any of the other Releasees) all but \$100 of the severance pay and cost of the severance benefits paid or made available to me. I further agree that the foregoing covenants in this paragraph (3) shall not affect the validity of this Waiver and Release Agreement and shall not be deemed to be a penalty nor a forfeiture.

(4) **Further Waiver And Acknowledgement.** To the extent permitted by law, I further waive my right to any monetary recovery should any federal, state, or local administrative agency pursue any claims on my behalf arising out of or related to my employment with and/or separation from employment with the Company and/or any of the other Releasees. I also acknowledge that I have not suffered any on-the-job injury for which I have not already filed a claim.

(5) **Reinstatement Rights.** To the extent permitted by law, I further waive, release and discharge Releasees from any reinstatement rights which I have or could have.

(6) **Non-Disparagement.** I also promise that I shall not at any time or in any way disparage the Company and/or any of the other Releasees to any person, corporation, entity or other third party whatsoever.

(7) **Consequences Of Other Breach.** I further agree that if I breach the Confidential Information/Cooperation provisions of the Plan or the provisions of paragraphs (5) and/or (6) above, then (a) the Company (and/or any of the other Releasees) shall be entitled to apply for without bond and receive an injunction to restrain such breach, (b) the Company (and/or any of the other Releasees) shall not be obligated to continue payment of the severance pay and availability of severance benefits to me, and (c) I shall be obligated to pay to the Company (and/or any of the other Releasees) its costs and expenses in enforcing the Confidential Information/Cooperation provisions of the Plan and the provisions of paragraphs (5) and (6) above (including court costs, expenses and reasonable legal fees).

(8) **Claim Or Refund.** If subsequent to my terminate date, the Company (and/or any of the other Releasees) discovers that it has overpaid Old-Age, Survivors and Disability Insurance Tax under Sections 3101 and 3111 of the Internal Revenue Code related to my employment with the Company (and/or any of the other Releasees), then I grant to the Company (and/or any of the other Releasees) my unconditional consent to file a claim for refund or credit of my portion of such overpayment. Furthermore, I have not or will not claim a refund or credit for any amount of over-collection of such tax without first notifying the Company (and/or any of the other Releasees).

Upon the Company's receipt of refund or granting of credit by the Internal Revenue Service of my portion of such overpayment, pursuant to the Company's (and/or any of the other Releasees) claim for refund or credit, the Company (and/or any of the other Releasees) shall within a reasonable period of time remit to me such over-collection of tax under Section 3101 of the Internal Revenue Code, to my last known residence.

Further and upon reasonable demand by the Company (and/or any of the other Releasees), I shall complete and timely deliver to the Company and/or other designated party(ies) any and all forms or documents that may be required or reasonably necessary with respect to the Company's (and/or any of the other Releasees) claim for refund or credit. The Company (and/or any of the other Releasees) retains within its discretion the right to set reasonable time periods for completion and delivery of said forms and documents.

(9) **Time To Consider Agreement.** I acknowledge that I have been given at least forty-five (45) days to consider this Waiver and Release Agreement thoroughly.

(10) **Attorney Consultation.** I acknowledge that I have been advised in writing to consult with an attorney at my own expense, if desired, prior to signing this Waiver and Release Agreement.

(11) **Time To Revoke Agreement.** I understand that I may revoke this Waiver and Release Agreement within seven (7) days after its signing and that any revocation must be made in writing and submitted within such seven day period to the Plan

Administrator at the address below. I further understand that if I revoke this Waiver and Release Agreement, I shall not receive the severance pay nor the severance benefits.

(12) **Consideration For Agreement.** I also understand that the severance pay and severance benefits which I will receive in exchange for signing and not later revoking this Waiver and Release Agreement are in addition to anything of value to which I already am entitled.

(13) **RELEASE OF UNKNOWN CLAIMS.** I FURTHER UNDERSTAND THAT THIS WAIVER AND RELEASE AGREEMENT INCLUDES A RELEASE OF ALL KNOWN AND UNKNOWN CLAIMS TO DATE.

(14) **Severability.** I acknowledge and agree that if any provision of this Waiver and Release Agreement is found, held or deemed by a court of competent jurisdiction to be void, unlawful or unenforceable under any applicable statute or controlling law, the remainder of this Waiver and Release Agreement shall continue in full force and effect.

(15) **Governing Law.** This Waiver and Release Agreement in all respects shall be interpreted, enforced and governed under applicable federal law and in the event reference shall be made to State law, the internal laws of the State of Illinois shall apply.

(16) **Acknowledgement.** I further acknowledge and agree that I have carefully read and fully understand all of the provisions of this Waiver and Release Agreement and that I voluntarily enter into this Waiver and Release Agreement by signing below.

Questions about severance pay and benefits should be directed to AskHR at 1-800-871-8877.

(Name of Eligible Employee - Please Print)

(Signature of Eligible Employee)

(Date)

PLEASE RETURN TO:

Plan Administrator
ABN AMRO GROUP
Human Resources Department: Severance Pay Plan
c/o Joan Schellhorn
LaSalle Bank Corporation
135 South LaSalle Street
Suite 3300
Chicago, IL 60603

LIST OF STATE LAWS TO INSERT IN WAIVER AND RELEASE

Instructions: The following is a list of state laws that should be inserted into Section 1(a) of the Waiver and Release Agreement, based upon the states in which the employees who will be asked to execute the Waiver and Release Agreement are located. There are two types of states listed:

1. States in which ABN AMRO has a significant number of employees. These states do not specifically require that the state law be listed in order for the release to be effective. However, insertion of the state law is generally desirable where the Waiver and Release Agreement will apply to employees located in that state.
2. States that have laws that specifically require that the state law be identified by name in the Waiver and Release Agreement in order for it to be effective. These states are identified by the word **REQUIRED**. The applicable language must be inserted to have a valid release with respect to any employee who is located in one of these states.

The language can be inserted directly into the Waiver and Release Agreement through a cut-and-paste operation.

California (REQUIRED)

"(for employees in California), including any claims of which you do know or suspect to exist in your favor at the time of executing this Waiver and Release Agreement, which if known by you must have materially affected your settlement with the Releasees, as defined in section 1542 of the California Civil Code"

Florida

"(for employees in Florida) the Florida Civil Rights Act and Florida Whistleblower Act"

Illinois

"(for employees in Illinois) the Illinois Human Rights Act, the Victims' Economic Security and Safety Act, the Illinois Right To Privacy in the Workplace Act, the Illinois Equal Pay Act of 2003, and the Illinois WARN Act,"

Michigan

"(for employees in Michigan) the Elliot Larsen Civil Rights Act, the Persons With Disabilities Civil Rights Act, MI ST § 750.556 (the Equal Pay Law),"

Minnesota (REQUIRED)

No special language, but the revocation period must be 15 days rather than seven to be valid under Minnesota law.

New York

"(for employees in New York) the New York Civil Rights Law, New York Labor Code § 194 (the Equal Pay Law), the New York Civil Rights Code § 40-c (the Equal Rights Law),

New Jersey REQUIRED (with respect to Conscientious Employee Protect Act only)

"(for employees in New Jersey) the New Jersey Conscientious Employee Protection Act, the New Jersey Law Against Discrimination, the New Jersey Wage Payment Law, the New Jersey Discrimination in Wages Law, the New Jersey Family Leave Act"

West Virginia REQUIRED

"(for employees in West Virginia) the West Virginia Human Rights Act (W. Va. Code §5-11-1)"

[LETTERHEAD OF EMPLOYER]

**AMENDMENT
TO THE
ABN AMRO GROUP SEVERANCE PAY PLAN**

WHEREAS, the ABN AMRO Group Severance Pay Plan (the "Plan") was amended and restated effective as of April 17, 2007;

WHEREAS, effective August 28, 2007, sponsorship of the Plan was transferred from ABN AMRO Bank N.V. to ABN AMRO North America Holding Company, which thereupon became the "Company" for all purposes of the Plan;

WHEREAS, it is now desirable to amend the Plan to reflect the change in Plan sponsorship; and

WHEREAS, effective September 30, 2007, the Plan shall be frozen in its entirety and no benefit thereunder shall be available to any person who terminates employment or who has not signed the required Waiver and Release Agreement with the Company after September 30, 2007.

NOW, THEREFORE, the Plan is amended as follows:

1. Effective August 28, 2007, all references to "Company" contained in the Plan shall mean ABN AMRO North America Holding Company;
2. Effective August 28, 2007, ABN AMRO North America Holding Company shall replace ABN AMRO Bank N.V. as Plan Administrator of the Plan and "named fiduciary" within the meaning of such terms as defined in ERISA.
3. Effective September 30, 2007, the Plan shall be frozen in its entirety and no benefits thereunder shall be available to any person who terminates employment or who has not signed the required Waiver and Release Agreement with the Company after September 30, 2007.
4. Effective October 1, 2007, a new term "Excluded Employer" shall be included to mean "ABN AMRO WCS Holding Company, ABN AMRO Asset Management, Inc., ABN AMRO Incorporated, ABN AMRO Advisory, Inc., ABN AMRO Associates Corp., their respective subsidiaries, ABN AMRO Bank N.V., and any other branch or subsidiary of ABN AMRO Bank N.V. other than ABN AMRO North America Holding Company and its subsidiaries.;" and
5. Effective October 1, 2007, all Excluded Employers, to the extent previously participating in the Plan, shall cease participating, and the Plan shall have no further liability for benefits payable to the active employees of an Excluded Employer.

In all other respects, the Plan, as heretofore amended and in effect, is hereby ratified and confirmed.

* * * *

IN WITNESS WHEREOF, ABN AMRO Bank N.V., as original sponsor of the Plan, and ABN AMRO North America Holding Company, as the new sponsor of the Plan, have caused this Amendment to be executed by their duly authorized representatives this 28th day of September, 2007.

ABN AMRO BANK N.V.	ABN AMRO NORTH AMERICA HOLDING COMPANY
By: Its: <u>Managing Board Member</u>	By: Its: <u>President and CEO</u>
By: Its: <u>Authorized Signatory</u>	

Exhibit 4

Your Guide to the Corporate Severance Program - Section 1

Legacy LaSalle Bank Corporation
October 1, 2007

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Career Opportunities and Relocation	Section 5
Severance Pay	Section 6
Benefits While Receiving Severance	Section 7
Benefits Grid	Section 8
Other Benefits	Section 9

The Bank of America Corporate Severance Program (CSP) is designed to help you through the transition period if you are displaced as a result of a workforce reduction, realignment or similar measure. This guide and the accompanying material in this folder contain important information affecting your participation in the CSP. Please take time to read them. We also encourage you to seek the advice of family, friends, financial advisors or others who can help you make decisions. After you have read this information, you may still have questions or want additional information. If so, please refer to the Important Telephone Numbers and Web sites listed in this guide.

For questions about the Corporate Severance Program, visit MyHR or call AskHR1.800.871-8877

Page 1 of 20

Revised: 10/01/2007

Important Telephone Numbers / How to Contact - Section 2

Ask HR	Telephone Number	Website Address
• Medical, Dental, Vision, Other Insurance, Pension, Pay Reimbursement Accounts	800.871.8877	MyHR website via Currency
Express Scripts	877.924.3967	www.wageworks.com
COBRA	800.451.1493	www.express-scripts.com
WorkLife Matters/ EAP	800.877.7994	n/a
Employment Verification	800.327.1092	n/a
401(k) AccessLine	800.367.5690	www.theworknumberto.com / company code 10183
CABL (Counsel for Adult and Experiential Learning)	800.328.3151	www.retirementplans.abnarrco.com
Alliance Bernstein \$29 CollegeBoundFund	888.608.2235	https://secure.iamsonline.org/TAKfS3Web/abnarrco
Finance (Controllers Customer Service)	888.324.5057	email: tuition-abnarrco@cael.org
IT Help Desk	312.904.4357	https://corporate.collegeboundfund.com
Outplacement Services (Lee Hecht Harrison)	877.226.8400	
	877.227.8917	

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871.8877

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To Do List - Section 3

Action	When
1. Complete, sign and return the General Release and Program Agreement ("CSP Agreement")	Within 45 days of your notification date
2. Complete, sign and return the Statement of Non-Revocation Form	8 days from the date the CSP Agreement was signed
3. Contact Outplacement Resources	As soon as possible, no later than 60 days from your termination date.

For questions about the Corporate Severance Program, visit MyHR or call AskHR1.800.871-8877

Severance Overview - Section 4

Severance Pay and Benefits

Now that you have officially received a copy of this guide, you will receive severance pay and other benefits if:

- You are displaced as a result of a workforce reduction, realignment or similar measure;
- You successfully perform your work until your position is officially eliminated;
- You do not receive a comparable job offer (see definition below) at Bank of America during your active employment; and
- You properly sign, date and return the CSP Agreement and Non-Revocation Form.

You could lose your eligibility for severance pay and the other benefits of the Corporate Severance Program if, while you are receiving severance pay or other benefits, the company becomes aware of circumstances that could have caused your immediate termination, such as embezzlement, dishonesty, or violations of the conditions of employment.

Comparable Job Offers

If you decline a comparable job offer, you will not be eligible for the Corporate Severance Program, including severance pay and related benefits. A comparable job, as defined by management, is generally:

- A job for which you are qualified;
- A job that does not reduce your base pay rate; and
- A job that does not require relocation or an excessive increase in your commute time (this criteria will be administered considering the commute "standards" for the geographic area, availability of public transportation, etc).

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871.8877

Severance Overview - Section 4 (continued)**Severance Pay**

Severance Pay shall be determined in accordance with the following table.

Eligible Employee's Employment Classification	Amount of Severance Pay (Base Salary)
Executive Vice President / Corporate Managing Director	Twenty-six (26) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of sixty-four (64) weeks of pay. Eligible to receive bonus as described below.
Group Senior Vice President / Senior Vice President / Executive Director / Managing Director or equivalent	Twenty-six (26) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of fifty-two (52) weeks of pay. Eligible to receive bonus pay as described below.
Vice President and First Vice President / Corporate Director / Director or equivalent	Sixteen (16) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of fifty-two (52) weeks of pay. Eligible to receive bonus pay as described below.
Officer / Associate and Assistant Vice President or equivalent	Twelve (12) weeks of pay plus two (2) weeks of pay for each year of service, to a maximum total of fifty-two (52) weeks of pay. Eligible to receive bonus pay as described below.
Exempt (non Officer) with at least 1 year of service	Six (6) weeks of pay plus one (1) week of pay for each year of service, with a minimum total of eight (8) weeks of pay and a maximum total of fifty-two (52) weeks of pay.
Nonexempt with at least 1 year of service	Four (4) weeks of pay plus one (1) week of pay for each year of service, with a minimum total of eight (8) weeks of pay and a maximum total of fifty-two (52) weeks of pay.
Exempt (non Officer) Or Nonexempt With Less Than One (1) Year of Service	Four (4) weeks of pay.

Severance pay for full-time hourly employees shall be based on the number of scheduled hours as of the termination date. Severance pay for part-time employees shall be based on the number of actual hours worked during the previous year of employment. Except as otherwise determined by Bank of America, an eligible employee whose termination date occurs more than six months from the most recent anniversary of his/her hire date (or adjusted hire date) shall be credited with an additional full year of service. The number of weeks of pay shall be determined by the employee's level as noted in the chart above.

In the case of an employee whose position is not listed above, the amount of severance pay will be determined by Bank of America in its discretion and set forth in the employee's notice of eligibility for severance.

Commissioned Associates

Commissioned associates will receive severance pay based on the benefits base pay determined each year for health and wellness coverage for purposes of annual enrollment.

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871-8877

Severance Overview - Section 4 (continued)

Incentive Pay

Eligible employees will receive severance for annual incentive programs in which they participate. The amount received will be prorated based on the number of full months completed. Production incentives will be paid based on the provisions of the individual plans.

Incentive Plan	Payout of Incentive
Annual Bonus	<p>An employee must be employed as of August 1 to qualify to receive a pro-rated bonus for the current year. The bonus will be pro-rated based on the number of complete months of service in that year. Any decision to include bonus payouts will be determined by management based on the employee's performance.</p> <p>CIP will be paid as soon as administratively possible based on the employee's assigned target percent that year.</p> <p>All other formulaic bonus programs will be paid as soon as administratively possible based on the average of the employee's bonuses over the last three years (if available).</p> <p>Discretionary bonuses will be paid as soon as administratively possible based on the previous year's bonus amount.</p>
Long Term Incentive Program	An employee must be employed as of August 1 to vest in the plan for the current year. The bonus will be pro-rated based on the number of complete months of service in the performance period.

Perks

Employee perks end as of the last day of employment.

Payment of Severance

You may elect to take your severance pay in the form of installments or as a lump sum payment. Details about your severance pay are covered in Section 6. Please note there are differences in benefit continuation if you choose a lump sum over installments.

Separation of Service / Termination of Employment Relationship

Your employment ends on your termination date (i.e., when you receive or begin receiving severance pay). Solely for the purpose of ensuring you are properly paid your severance pay and benefits extended, Bank of America will continue to reflect your employment in its automated payroll/personnel records until your severance pay ends.

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871-8877

Career Opportunities and Relocation - Section 5

Discovering New Career Opportunities

In order to assist you in your transition to other employment, Bank of America has agreed to provide eligible employees with career transition assistance services provided by an outplacement firm selected and paid for by Bank of America. This transition assistance will be provided at such level of services as determined by Bank of America. An eligible employee must begin the available career transition services within sixty (60) days following his/her termination of employment with Bank of America.

Recognizing that each individual has different needs, career goals and interests, the first step is to utilize the resources available to you. Take advantage of the Internet: use it to research potential career opportunities. You may also want to contact WorkLife Matters for information on dealing with change, as well as researching local employment and job search agencies.

The sooner you begin this process, the greater your potential for success.

Please refer to the Transition / Outplacement Support Services and Inplacement materials in your severance package for the services available to you.

Relocation

If a comparable job is not available in your current location, and you are offered a job within the company in another city, relocation assistance may be available. Your Human Resources Manager will discuss the details of the relocation package with you if you are interested in relocating.

Severance Pay - Section 6

Treatment of Final Pay

You will receive final pay for time worked prior to your termination date on the first semi-monthly payroll following the separation date, as practical. You will receive your payment either by direct deposit or live check (the same way your wages had previously been paid). In order to receive direct deposit, you are requested to leave your account open until final pay and vacation pay (if applicable) is deposited. If you are receiving severance, you may also leave your direct deposit account open though the end of your severance period.

Treatment of Severance Pay

You may elect to have your severance pay paid to you in a lump sum or in installments. Installment pay is paid coinciding with your regular pay schedule. Your CSP Agreement will allow you to select a form of payment for your severance pay (lump sum or installments). Keep in mind that if you choose a lump sum, you will not be eligible to continue any benefits, such as health care coverage, at the active associate rate.

If you receive your severance pay in installments, you will be taxed at your current withholding rate.

If you choose to receive a lump sum payment, you will be taxed at the following "special pay flat rate":

- 28% or the current applicable federal income tax
- Applicable state income tax (for example, 6 % for California)
- Social Security and Medicare deductions; and
- Any other applicable state or local taxes

You must complete the CSP Agreement indicating how you would like to receive your severance pay (installments or lump sum). If you do not complete the payment election on your CSP Agreement, your severance will automatically be paid to you in installments.

**Please note that in order to receive severance pay and benefits, an eligible employee must submit the CSP Agreement within 45 days after the notification date and the Statement of Non-Revocation no earlier than eight (8) days from the date the CSP Agreement was signed.*

Severance Pay - Section 6 (continued)

You will be paid for any unused accrued vacation and/or floating holiday hours that you have accumulated for the current year. You will not be paid for any unused personal or sick days. Please refer to the following schedules for final year vacation and floating holiday accrual:

Month of Termination	Final Vacation Days		
	10 Days*	15 Days*	20 Days*
January	0	0	0
February	1	2	3
March	2	4	5
April	3	5	7
May	4	6	8
June	5	8	10
July	6	9	12
August	7	10	13
September	7	11	15
October	8	13	17
November	9	14	18
December	10	15	20

* This table assumes employee is eligible for the full vacation allotment in the calendar year.

Floating Holidays

1 st Quarter - 0 days	3 rd Quarter - 1 day
2 nd Quarter - 1 day	4 th Quarter - 2 days

*Quarter Century Day (if applicable) will also be paid out if not taken

In the event you receive an overpayment of your regular, final or severance pay, you must repay it. You are only entitled to receive severance pay that exceeds any amount(s) you owe the company resulting from your employment (for example, business credit cards, outstanding salary overpayment, used but not accrued vacation, etc.).

For questions regarding your severance paycheck, please contact AskHR.

Re-employment

If, during the time you are receiving severance pay, you are rehired within Bank of America, your installment severance pay will be discontinued and your regular pay will begin. If you received your severance payment in a lump sum, you will generally be required to pay back a pro-rated portion.

This policy may also be in effect in the case of company divestitures or sales, or the contracting out or outsourcing of a unit's functions or services. Your severance pay may stop if you begin work during this same time period with the purchaser of the organization to which your business unit's functions or services were outsourced.

For questions about the Corporate Severance Program, visit MyHR or call AskHR1.800.871-8877

Benefits While Receiving Severance - Section 7

As a participant in the Corporate Severance Program, you are eligible to continue coverage in the following benefits while you are receiving severance.

Note: If you were not eligible for or participating in the benefits programs discussed in this Guide, CSP participation does not entitle you to receive or participate in these benefits programs.

Health and Wellness Benefits

Generally, you may continue most of your benefits at the active associate rates, on a pre-tax basis, while you are receiving severance pay. For details about what happens to your benefits as a result of your displacement, please refer to the benefits chart in Section 8.

Note: Any pay received after your severance pay ends will not extend your benefits end date.

Payment of Health and Wellness Benefits

If you elect to receive your severance pay in installments, payment for health and wellness coverage will be automatically deducted in the same manner as your deductions were taken from your active pay. You may cancel your coverage within 31 days of your end of active employment or within 31 days of a Qualified Status Change by sending your request via fax to 312-992-1611, via U.S. mail to 540 W. Madison, Suite 1102, Chicago, IL 60661. You may also change or cancel your coverage during annual enrollment if your severance pay installment continues into the following year. If you cancel your coverage, you are eligible to continue your medical, dental and vision coverage, and health care reimbursement account contributions at a higher premium through the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA information will be mailed to your home within 45 days after your active coverage ends.

Unless you choose to end your active coverage prior to your severance pay end date (discussed above), your health and wellness coverage through Bank of America stops at the end of the month in which you receive your last severance pay. Refer to the Benefits Grid (Section 8) for more detailed information.

Payment of Health and Wellness Benefits if Retirement Eligible

If you are eligible for retirement at end of active employment, your health and wellness coverage continues at the active rates until the end of your severance pay. If you wish to initiate retirement benefits, it is recommended that you contact AskHR sixty (60) days prior to your desired retirement date. You are eligible for retiree medical and dental coverage if you elect to start your pension benefit at the time of retirement or at the end of special pay. If you do not elect retiree medical and dental benefits when you are first eligible, you will not be able to elect such benefits at a later date. You must currently participate in the medical and dental programs as an active employee in order to receive coverage. If you declined coverage as an active employee, retired medical and dental benefits are not available to you. If eligible, you may retire at the time your severance begins. You can collect both your pension benefit and severance benefit concurrently and commence retiree medical (if elected coverage as an active employee) at the time your health and wellness severance benefits end.

Coverage Under COBRA

When your coverage ends at the end of the month in which your severance ends, you may elect to continue your medical, dental and vision coverage and health care reimbursement account contributions through COBRA (including Domestic Partner coverage). If you elect COBRA, the effective date of your COBRA coverage will be the first day of the next month following the date in which your active coverage ends, to prevent a break in coverage. COBRA information will be mailed to your home within 45 days after your active coverage ends. You will have 60 days from the date COBRA information is mailed to you to elect COBRA coverage. If you (or any qualified beneficiary) fail to elect COBRA coverage within this 60-day period, all rights to COBRA coverage are forfeited.

For questions about the Corporate Severance Program, visit MyHR or call AskHR1.800.871-8877

Benefits While Receiving Severance - Section 7 (continued)

401(k) Savings Plan

While on severance, contributions can no longer be made to the 401(k) Savings Plan and you will be treated as a terminated associate under those plans.

Pension Plan

Company contributions cease at the end of active employment. If you have completed five years of service and are eligible for a pension benefit, you will automatically receive notification of these benefits as soon as administratively possible.

Please refer to the benefits grid in section 8 for specific details on the benefits that continue during severance.

Benefits Grid - Section 8

Below is a summary of how the major benefit and associate programs are affected by your participation in the Corporate Severance Program. See also the list of Important Telephone Numbers and Web sites in Section 2 and the benefit information in Section 7 of the Guide.

This chart is a summary only and is not all-inclusive. For more complete information, please contact AskHR. The information in this chart is subject to the provisions of the official plan documents for each benefit, which govern the availability and amount of benefits. If there is an inconsistency between this benefit information and the provisions of the official plan documents, the plan provisions will always govern.

Health and Wellness Coverage	If You Elect To Receive Instalment Severance Pay	If You Elect a Lump Sum Severance Payment
➤ Medical	Coverage continues through the end of the month in which severance pay ends.	Coverage will end at the end of the month in which you receive your lump sum severance pay.
➤ Dental	Coverage continues through the end of the month in which severance pay ends.	Coverage will end at the end of the month in which you receive your lump sum severance.
➤ Vision	Coverage continues through the end of the month in which severance pay ends.	Coverage will end at the end of the month in which you receive your lump sum severance pay.
➤ Health Care Reimbursement Account	Your contributions continue through the end of the month in which severance pay ends. You have until March 31 st of the following year to file claims for eligible expenses incurred during the time you were contributing.	Coverage will stop at the end of the month in which you receive your lump sum payment. You have until March 31 st of the following year to file claims for eligible expenses incurred during the time you were contributing.
➤ Transportation or Parking Reimbursement Accounts	Deductions end on the last day you are actively employed. You may only submit reimbursement expenses incurred prior to your termination date. Reimbursement claims must be received by January 31 st of the following year.	Deductions end on the last day you are actively employed. You may only submit reimbursement expenses incurred prior to your termination date. Reimbursement claims must be received by January 31 st of the following year.

For questions about the Corporate Severance Program, visit AskHR or call AskHR 1.800.871.8877

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Benefits Grid - Section 8 (continued)

Health and Wellness Coverage	If You Elect To Receive Installment Severance Pay	If You Elect a Lump Sum Severance Payment
► COBRA	<p>COBRA coverage begins at the end of your severance period and is generally available for at least 18 months once active coverage ends for medical, dental and vision coverage. After-tax contributions may be made to your Health Care Reimbursement Account through the year in which you receive your lump sum severance pay.</p> <p>Note: COBRA is an extension only of the coverage that you already had, including Domestic Partner coverage, unless you experience a qualified status change.</p>	<p>COBRA coverage begins on the first of the month following your severance lump sum payment date and is generally available for at least 18 months once active coverage ends for medical, dental and vision coverage. After-tax contributions may be made to your Health Care Reimbursement Account through the year in which you receive your lump sum severance pay.</p> <p>Note: COBRA is an extension only of the coverage that you already had, including Domestic Partner coverage, unless you experience a qualified status change.</p>
Associate Basic Life Insurance, Associate Supplements, Life Insurance, Spouse Life Insurance, Dependent Child Life Insurance	<p>If you currently have basic, supplemental, and/or dependent life insurance coverage, this coverage ends on the last day of the month in which you terminate employment. You will be contacted by Prudential, our Life Insurance carrier, by mail regarding your option to convert your coverage to an individual policy. You will have 31 days from the date of the letter from Prudential to convert this coverage.</p>	<p>If you currently have basic, supplemental, and/or dependent life insurance coverage, this coverage ends on the last day of the month in which you terminate employment. You will be contacted by Prudential, our Life Insurance carrier, by mail regarding your option to convert your coverage to an individual policy. You will have 31 days from the date of the letter from Prudential to convert this coverage.</p>
Accidental Death & Dismemberment and Business Travel Accident Coverage	<p>AD & D and Business Travel Accident benefits end at the end of active employment.</p>	<p>AD & D and Business Travel Accident benefits end at the end of active employment.</p>

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871.8877

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Benefits Grid - Section 8 (continued)

Health and Wellness Coverage	If You Elect To Receive Instalment Severance Pay	If You Elect a Lump Sum Severance Payment
➤ Long-Term Disability	Coverage ends at the end of active employment.	Coverage ends at the end of active employment.
➤ Dependent Care Reimbursement Account	Deductions stop at the end of active employment. You have until March 31st of the following year to file claims for eligible expenses incurred between your participation date and the coverage end date, up to the amount contributed.	Deductions stop at the end of active employment. You have until March 31st of the following year to file claims for eligible expenses incurred between your participation date and the coverage end date, up to the amount contributed.

For questions about the Corporate Severance Program, visit MyHR or call AskHR, 1.800.871-8877

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Benefits Grid - Section 8 (continued)

Retirement Plans (401(k) and Pension)	If You Elect To Receive Installment Severance Pay	If You Elect a Lump Sum Severance Payment
► Contributions	<p>401(k): Contributions cease at the end of active employment.</p> <p>Pension: Company contributions cease at the end of active employment.</p>	<p>401(k): Contributions cease at the end of active employment.</p> <p>Pension: Company contributions cease at the end of active employment.</p>
► Vesting	<p>401(k): Eligible associates are fully vested at the time of enrollment in the plan.</p> <p>Pension: Eligible associates are fully vested after completion of five (5) years of active service.</p>	<p>401(k): Eligible associates are fully vested at the time of enrollment in the plan.</p> <p>Pension: Eligible associates are fully vested after completion of five (5) years of active service.</p>
► Company Match for 401(k) Plan	<p>Company match is made in cash each pay period that you contribute. If you are entitled to a year-end true-up match, it will be made after the end of the year, or when you request distribution, if earlier.</p>	<p>Company match is made in cash each pay period that you contribute. If you are entitled to a year-end true-up match, it will be made after the end of the year, or when you request distribution, if earlier.</p>
► Fund Reallocations	<p>Fund reallocations are available at any time prior to final distribution.</p>	<p>Fund reallocations are available at any time prior to final distribution.</p>
► Loans	<p><u>No new loans may be requested after the end of active employment.</u></p>	<p><u>No new loans may be requested after the end of active employment.</u></p>
► Pension Plan Distribution	<p>If you have an outstanding Plan loan, you must repay your loan within 90 days of your termination of employment or it will be defaulted and be considered a taxable event, with an additional tax penalty, if applicable. For loan payoff information, contact the 401(k) AccessLine.</p>	<p>If you have completed five years of service and are eligible for a pension benefit, you will automatically receive notification of these benefits as soon as administratively possible.</p>
		<p>If you have completed five years of service and are eligible for a pension benefit, you will automatically receive notification of these benefits as soon as administratively possible.</p>

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.371-8877

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Benefits Grid - Section 8 (continued)

Retirement Plans (401(k) and Pension)	If You Elect To Receive Instalment Severance Pay	If You Elect a Lump Sum Severance Payment
➤ 401(k) Savings Plan Distribution	<p>If you have a balance in your 401(k) Savings Plan you will automatically receive notification of this benefit within 30 days of termination. This notification contains required notices and directs you to call the 401(k) AccessLine at (800) 328-3151 to request a distribution with a customer service representative. No forms or paper are required.</p> <p>If you have a current balance in your account of \$5000 or more, you may wish to leave your account open. You will continue to accrue interest (or take any losses on portfolio performance) on your account until you take a distribution. If you decide to leave your account open, you will be able to continue making investment changes. You can do this by contacting the 401(k) AccessLine at (800) 328-3151 or by accessing your account online at retirementplans.abnarmro.com.</p>	<p>If you have a balance in your 401(k) Savings Plan you will automatically receive notification of this benefit within 30 days of termination. This notification contains required notices and directs you to call the 401(k) AccessLine at (800) 328-3151 to request a distribution with a customer service representative. No forms or paper are required.</p> <p>If you have a current balance in your account of \$5000 or more, you may wish to leave your account open. You will continue to accrue interest (or take any losses on portfolio performance) on your account until you take a distribution. If you decide to leave your account open, you will be able to continue making investment changes. You can do this by contacting the 401(k) AccessLine at (800) 328-3151 or by accessing your account online at retirementplans.abnarmro.com.</p> <p>If your account balance is less than or equal to \$1,000 your account may be automatically paid to you in a lump sum cash payment. If you do not wish to receive a lump sum cash payment you must call the 401(k) AccessLine to request a direct rollover.</p> <p>If your account balance is between \$1,000 and \$5,000, your account may be automatically rolled over to an IRA established by your employer. The IRA will be an IRA sponsored by LaSalle Bank N.A. If you do not wish to have your account automatically rolled over to an IRA you must call the 401(k) AccessLine to request a lump sum or direct rollover payment.</p>

For questions about the Corporate Severance Program, visit [MyHR or call AskHR 1-800-871-8877](http://MyHR.or call AskHR 1-800-871-8877)

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Benefits Grid - Section 8 (continued)

Work / Life and Time Off Programs	If You Elect To Receive Instalment Severance Pay	If You Elect a Lump Sum Severance Payment
➤ Vacation <i>See the "Severance Pay" section for details on how you will be paid for any unused vacation or how your pay will be deducted for vacation used but not accrued.</i>	Accrual of vacation stops at the end of your active employment. You will be paid for any vacation time accrued but not taken at the time you begin receiving severance pay. If you've taken more vacation than you have accrued, the pay advance for the unearned hours of vacation may be reconciled from your final pay, or otherwise recovered from you.	Accrual of vacation stops at the end of your active employment. You will be paid for any vacation time accrued but not taken at the time you begin receiving severance pay. If you've taken more vacation than you have accrued, the pay advance for the unearned hours of vacation may be reconciled from your final pay, or otherwise recovered from you.
➤ Floating Holidays/Quarter Century Day	Accrual of floating holidays stops at the end of your active employment. You will be paid for any floating holiday(s) accrued but not taken at the time you begin receiving severance pay. If you've taken more floating holidays than you have accrued, the pay advance for the unearned floating holidays may be reconciled from your final pay, or otherwise recovered from you.	Accrual of floating holidays stops at the end of your active employment. You will be paid for any floating holiday(s) accrued but not taken at the time you receive your lump sum. If you've taken more floating holidays than you have accrued, the pay advance for the unearned floating holidays may be reconciled from your final pay, or otherwise recovered from you.
	Quarter Century Day will be paid out if not taken.	Quarter Century Day will be paid out if not taken.
➤ Personal Days	You will not be paid for any unused Personal days.	You will not be paid for any unused personal days.
➤ Sick Days	You will not be paid for any unused sick days.	You will not be paid for any unused sick days.

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871-8877

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Benefits Grid - Section 8 (continued)

Work / Life and Time Off Programs	If You Elect To Receive Instalment Severance Pay	If You Elect a Lump Sum Severance Payment
➤ Leaves of Absence	Once the associate has received the formal severance package, a leave of absence cannot be set up.	Once the associate has received the formal severance package, a leave of absence cannot be set up.
➤ WorkLife Matters/EAP	Continues through your severance pay.	Not eligible to participate after lump sum severance pay has been received.
➤ Educational Reimbursement Program	You will not be responsible for repaying any tuition benefit obligations. In addition, you will be eligible for reimbursement for the current classes (or term) in which you are currently enrolled. Employees participating in the program must notify CAEL for reimbursement.	You will not be responsible for repaying any tuition benefit obligations. In addition, you will be eligible for reimbursement for the current classes (or term) in which you are currently enrolled. Employees participating in the program must notify CAEL for reimbursement.
➤ Adoption Assistance Program	You are eligible to receive reimbursement for any eligible adoption proceedings that began prior to the end of your active employment.	You are eligible to receive reimbursement for any eligible adoption proceedings that began prior to the end of your active employment.

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871.8877

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Other Benefits - Section 9

Banking Services

If you have direct deposit, you may continue to use this service throughout your severance period. If you maintain "fee free", "employee checking" or "brokerage" accounts with any entity of ABN AMRO, they must be converted to another type of checking account immediately after your severance period ends. If you do not transfer, your account will automatically be converted to the Convenience Checking account within 30 days after your termination.

We value your account relationship and recommend that you contact your nearest branch to assist you in the selection of an account that will best meet your financial needs.

Employment Verification

All requests for employment verifications must be processed through The Work Number. Verifiers may access The Work Number system by calling (800) 367-5690 or at www.theworknumber.com. The ABN AMRO company code is 10583. Customer Service can be reached at (800) 996-7566 if you or the verifier have any questions.

Unemployment Insurance

If you wish to file a claim for unemployment insurance benefits, you should file when or after severance pay begins. When filing your claim, you should go to the state unemployment office nearest to your place of residence.

Illinois residents may file a claim for unemployment benefits by internet at www.illinois.gov or at your local Illinois Employment & Training Center (IETC) office. A list of local offices may be found on the website, or you may call 1-888-FOR-IETC (367-4382) to find the nearest office.

Michigan residents may file a claim for unemployment benefits with the Michigan Unemployment Insurance Agency by telephone at (866) 500-0017 or by internet at www.michigan.gov/ua.

Florida residents may file a claim for unemployment benefits with the Florida Agency for Workforce Innovation (AWI) by internet at www.floridajobs.org/unemployment or by visiting a local AWI One Stop Center. Addresses and phone numbers of One Stop Centers are listed on the internet site.

New Jersey residents may file a claim for unemployment benefits with the New Jersey Department of Labor & Workforce Development by internet at www.nj.gov/labor or by calling 609-633-6400.

New York residents may file a claim for unemployment benefits with the New York Department of Labor by internet at www.labor.state.ny.us/ or by calling 518-457-2635.

If eligible, Bank of America will not contest any claim for unemployment compensation that you may file.

For questions about the Corporate Severance Program, visit MyHR or call AskHR 1.800.871-8877

Other Benefits - Section 9 (continued)

DEFERRED BONUSES/ANNUAL BONUS PLANS - (If Applicable)

You will receive a lump sum distribution of your deferred bonus according to the terms of the plan. If you choose to retire concurrently while on severance, you will receive a distribution of your deferred bonus per the irrevocable distribution method you elected. If you have further questions, please contact Tonie Hawkins in CoB Rewards at (312) 904-2960.

LONG TERM INCENTIVE PLANS - (If Applicable)

The bonus payout will be made in accordance with the plan documents. The payment will be automatically issued to the DDA account you currently have on file with the Payroll Department and a pay advice will be mailed to your home. If you need to change your account information and/or your address, please contact AskHR at (800) 871-8877.

If you have a question about LTIP, please contact AskHR at (800) 871-8877.

Your Guide to the Corporate Severance Program - Section 4

Legacy LaSalle Bank Corporation
October 1, 2007

Addendum to page 6, Incentive Pay

Bank of America will honor the bonus guarantees that have been made to associates for 2007. For those participating in an annual bonus plan and whose positions are eliminated on or after October 1, 2007, you may be eligible for an additional incentive for over achievement as outlined in your 2007 bonus guarantee letter. Payments will be made in accordance with the terms and conditions of the plan.

November 15, 2007

Exhibit 5

**BANK OF AMERICA
TRANSITION ASSISTANCE POLICY**

Adopted effective June 1, 1999

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BANK OF AMERICA
TRANSITION ASSISTANCE POLICY

ARTICLE I
NAME, PURPOSE AND EFFECTIVE DATE

1.1 Name. This document shall be known as the Bank of America Transition Assistance Policy (the "Plan"). The Plan is part of the Group Benefits Program.

1.2 Purpose. The purpose of the Plan is to help ease the transition to new employment for Associates displaced on account of workforce reduction, realignment or similar measure, as determined by the Participating Employers in their sole discretion, who are eligible under the Plan.

1.3 Effective Date. The Plan is effective June 1, 1999.

ARTICLE II
DEFINITIONS

The following terms, when used with initial capital letters, shall have the meanings set forth below:

2.1 Associate means a common law employee of the Company or any Subsidiary who is identified as an employee in the personnel records of such entity.

2.2 Committee means the Bank of America Corporation Corporate Benefits Committee, consisting of senior officers of the Company or its Subsidiaries who shall be appointed initially by and serve at the pleasure of the Board of Directors of the Company.

2.3 Company means Bank of America Corporation.

2.4 Effective Date means June 1, 1999.

2.5 Eligible Associate means an Associate described in Section 3.1.

2.6 ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.7 Group Benefits Program means the NationsBank Group Benefits Plan, as amended from time to time, and any successor to such plan.

2.8 Participating Employer means the Company or any Subsidiary which participates in the Group Benefits Program.

2.9 Plan means the Bank of America Transition Assistance Policy as set forth in this document and as amended from time to time. The Plan is part of the Group Benefits Program.

2.10 Plan Year means the calendar year.

2.11 Subsidiary means any corporation, partnership, joint venture, affiliate, or other entity in which the Company owns directly or indirectly more than fifty percent (50%) of the voting stock or voting ownership interest, as applicable, or any other business entity designated by the Committee as a Subsidiary for purposes of the Plan.

2.12 United States means the fifty (50) states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands.

ARTICLE III
ELIGIBILITY FOR TRANSITION ASSISTANCE

3.1 Eligible Associates. An Associate shall be eligible to participate in the Plan if all of the following conditions are satisfied:

- (a) The Associate is employed by a Participating Employer, and is not in a unit, division, category or group of Associates which the Company or the applicable Participating Employer has determined in its sole discretion to be ineligible for the Plan.
- (b) The Associate is based in the United States.
- (c) The Associate is being displaced due to workforce reduction, realignment or similar measure as determined by the applicable Participating Employer in its sole discretion and the Associate has been officially notified in writing of his or her displacement and eligibility for the Plan by an authorized representative of such Participating Employer.

3.2 Transition Assistance. The Participating Employers will determine in their sole discretion the amount, if any, of transition assistance, including severance pay, which may be available from time to time to Eligible Associates.

- (a) If transition assistance, including severance pay, is made available, the amount, if any, and type may vary by unit, division, category or group, or based on the reason for the Eligible Associate's displacement, (including displacement due to a corporate transaction as described in Section 3.4) or based on such other factors as the Company or applicable Participating Employer deems appropriate in its sole discretion.
- (b) The applicable Participating Employer shall determine in its sole discretion the reason for an Eligible Associate's displacement, including whether an Associate's displacement is a direct result of a particular corporate transaction. In making such determination, the Participating Employer shall consider such factors as it deems appropriate.
- (c) A unit or division of a Participating Employer may, with the consent of such Participating Employer, determine the amount, if any, of transition assistance, including severance pay, available to Eligible Associates displaced from such unit or division, or from a category or group of Associates within such unit or division.
- (d) On or about the time an Eligible Associate is officially notified of displacement and eligibility for the Plan by an authorized representative of the applicable Participating Employer, the Associate will be provided information about the transition assistance, including the amount of severance pay, if any, that is available to the Associate.

3.3 Conditions to Receipt of Benefits. In order to be eligible to receive severance pay and other transition assistance, an Eligible Associate must satisfy the following conditions:

- (a) The Eligible Associate must continue to perform his or her job duties in a satisfactory manner until the date specified by the Participating Employer (the "position elimination date"). If the Associate does not continue to perform his or her job duties in a satisfactory manner or resigns employment before the position elimination date, the Associate will not be eligible for any benefits under the Plan.
- (b) The Eligible Associate must sign, and not revoke, a general release and settlement agreement (the "release") of claims against the Participating Employer and their affiliates and related parties (including, without limitation their officers, directors, employees, agents, representatives and benefit plans) at the time and in the form specified by the Company. The release may contain the Associate's express agreement to Section 5.3 of the Plan. The release may contain such other provisions as the Company may specify, including but not limited to, the Associate's agreement to not disclose confidential business information, to not disparage the Company and its Subsidiaries and to refrain from (or engage in) certain acts affecting the Company and its Subsidiaries, including, but not limited to, not competing with, or soliciting employees or customers of, the Company and its Subsidiaries.
- (c) (1) If the Associate is offered a comparable position, as determined by the applicable Participating Employer in its sole discretion, with the Company or any Subsidiary, the Associate will no longer be eligible for transition assistance, including severance pay, whether or not the Associate accepts the position being offered. The Company may adopt guidelines, which it may change at any time in its sole discretion, regarding which positions are comparable positions for purposes of the Plan.
(2) If the Associate accepts another position with the Company or any Subsidiary, regardless of whether such position is a comparable position, the Associate will no longer be eligible for transition assistance, including severance pay, unless the Company determines otherwise in its sole discretion.
(3) If the Participating Employer becomes aware of any circumstance which could have caused the immediate termination of the Associate, the Associate will not be eligible for transition assistance, including severance pay. Upon demand from the Participating Employer, such Associate shall immediately return to the Participating Employer any transition assistance, including severance pay, received by the Associate.
(4) If, after the Associate terminates employment with the Participating Employer, the Associate accepts a position with the Company or any

Subsidiary within the time period for which the severance pay was paid, the Associate shall be obligated to return a pro rata portion of such severance pay upon demand by the Participating Employer. The pro rata portion shall be based on the period of the Associate was not employed: for example, if an Eligible Associate received severance pay equal to 12 months salary and is rehired after 4 months, the Associate would be obligated to repay eight-twelfths (8/12) of the severance pay, upon demand by the Participating Employer.

(d) The Eligible Associate must satisfy any other conditions established by the Company or the applicable Participating Employer.

3.4 Acquisitions and Divestitures and Similar Transactions. Transition assistance, including severance pay, does not apply to Associates whose employment is affected by acquisitions, sales, divestitures, outsourcing, the contracting out of functions and similar transactions ("corporate transactions") unless an authorized representative of the Participating Employer specifically determines otherwise and notifies the affected Associates in writing.

If transition assistance, including severance pay, is made available in connection with a particular corporate transaction, the following sentence shall apply, in addition to the conditions in Section 3.3: If the Associate is offered or has available a position with the other party to the corporate transaction, or any affiliate or subsidiary of such party, which the Participating Employer determines, in its sole discretion, to be an appropriate position for the Associate, the Associate shall not be eligible for transition assistance, including severance pay, whether or not the Associate accepts or works in the position. The Company may adopt guidelines which it may change at any time in its sole discretion, regarding which positions with the other party to a corporate transaction are appropriate positions for purposes of the Plan. For purposes of this paragraph, a position may be considered appropriate for the Associate even though it would not be considered a comparable position if offered by the Company or a Subsidiary.

ARTICLE IV
AMENDMENT AND ADMINISTRATION

4.1 Sponsor. The Company is the sponsor of the Group Benefits Program, which includes the Plan. The Company may alter, amend, suspend or terminate the Plan in whole or in part at any time by a written instrument executed by an authorized officer of the Company. The Company may authorize officers of Participating Employers to take actions on behalf of the Company with respect to the Plan, including but not limited to the execution of contracts and other documents relating to the Plan.

4.2 Plan Administration. The Committee shall be responsible for administration of the Plan.

4.3 Powers and Duties of Committee.

(a) The Committee shall have discretionary authority to determine eligibility for and to construe the terms of the Plan. The Committee shall have such other discretionary authority as may be necessary to enable it to discharge its responsibilities under the Plan, including, but not limited to, the power to:

(1) Resolve disputes concerning eligibility and participation in the Plan and the amount of transition assistance, including severance pay, available to an Eligible Associate, including the ability to make factual determinations.

(2) Delegate responsibility for the administration of the Plan, including the authority to review denied claims, and appoint or employ one or more persons to assist in the administration of the Plan or to render advice with regard to any of its responsibilities under the Plan.

(3) Adopt such rules as it deems appropriate for the administration of the Plan.

(4) Prescribe procedures to be followed by Associates.

(5) Prepare and distribute information relating to the Plan.

(6) Request from Participating Employers and Associates such information as shall be necessary for proper administration of the Plan.

(b) The decision of the Committee or its delegate upon any matter within its authority shall be final and binding on all parties, including the Company, the Participating Employers and Associates and former Associates.

4.4 Reliance Upon Information. In making decisions under the Plan, the

Committee and its delegates may rely upon information furnished by, or at the request of, an Associate or Participating Employer.

4.5 Action by Committee. The Committee may act either at a meeting (in person or by telephone or similar means) or, in the absence of a meeting, by an instrument in writing signed by a majority of the Committee members. The Committee may elect one of its members as chairperson and appoint a secretary to keep a record of all meetings and forward any necessary communication to the Participating Employers. The Committee may adopt such bylaws for the conduct of its business as it deems desirable. All decisions of the Committee shall be made by a majority vote including actions taken without a meeting.

4.6 Claims Procedure.

(a) An Associate or other person (the "claimant") who has a claim for benefits under the Plan must submit a written notice of such claim to the applicable Participating Employer. All claims must be submitted within six months from the date the claim for benefits arose.

(b) The claim shall be decided within 90 days by the Participating Employer (unless special circumstances require an extension of up to 90 additional days). Written notice of the decision on such claim shall be furnished promptly to the claimant. If the claim is wholly or partially denied, such written notice shall:

(1) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan;

(2) describe any additional information or material needed to support the claim and explain why such information or material, if any, is necessary; and

(3) describe the review procedures in subsection (c).

(c) A claimant may request a review of such decision denying the claim. Any such request must be filed in writing with the Committee within 90 days after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information which the claimant wishes to be considered.

(d) Written notice of the decision on review shall be furnished to the claimant within 60 days (unless special circumstances require an extension of up to 60 additional days) following the receipt of the request for review. The written notice of the decision by the Committee or its delegate shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan on which the decision is based.

(e) No legal action concerning the claim may be brought by the

claimant unless and until all of the following have occurred:

- (1) The claimant has submitted a timely written claim.
- (2) The claimant has been notified that the claim is denied.
- (3) The claimant has filed a timely written appeal with the Committee for review of the denied claim.
- (4) The claimant has been notified in writing of the decision of the Committee or its delegate or the Committee or its delegate has failed to take any action on the request for review within the time prescribed above.

4.7 Agency of Company. By becoming a party to the Plan, each Participating Employer designates the Company as its agent with authority to act for it in all transactions in which the Company believes such agency will facilitate the implementation or operation of the Plan, including authority to alter, amend, suspend or terminate the Plan in whole or part at any time.

4.8 Disaffiliation and Withdrawal from Program. Any Participating Employer which has participated in the Plan and which thereafter ceases for any reason to be a Participating Employer shall immediately cease to be a party to the Plan. In addition, any Participating Employer may, by written instrument executed by an authorized officer of such entity, elect to withdraw from participation in the Plan for such entity and its Associates.

ARTICLE V
GENERAL PROVISIONS

5.1 Nontransfereability of Benefits. No benefit under the Plan may be sold, transferred, pledged, assigned, or otherwise alienated or hypothecated, voluntarily or involuntarily, other than by will or by the laws of descent and distribution, and any attempt to do so shall be void. Notwithstanding anything contained in the preceding sentence, the applicable Participating Employer shall have the right to offset from any benefit under the Plan the amount due and owing from the Associate to the Company or any Subsidiary to the extent permitted by law.

5.2 Employment. Nothing in the Plan shall interfere with or limit in any way the right of the Participating Employers to terminate any Associate's employment without notice at any time, confer upon any Associate any right to continue in the employ of the Company or any Subsidiary, or change an Associate's existing at will employee status. Nothing in the Plan shall cause an employee of a Subsidiary to be an employee of the Company. Each Associate remains an employee of the Participating Employer that directly pays the Associate's wages.

5.3 Ineligibility for Other Separation Pay. If an Eligible Associate receives transition assistance, including severance pay, under the Plan, the Associate shall not be eligible to receive severance pay or separation benefits under any other plan, program, policy, guideline or practice of the Company or any Subsidiary, or under any agreement between the Associate and the Company or any Subsidiary.

5.4 Withholding for Taxes and Benefits. The Company shall have the right to deduct or withhold from the transition assistance, including severance pay, an amount sufficient to cover withholding required by law for any federal, state or local taxes or to take such other action as may be necessary to satisfy any such withholding or similar legal obligation. The Company shall also have the right to deduct or withhold from the transition assistance, including severance pay, any amounts due from the Associate under any employee benefit plan sponsored by the Company in which the Associate is participating.

ARTICLE VI
LEGAL CONSTRUCTION

6.1 Gender and Number. Unless the context plainly indicates otherwise, words in any gender include the other genders and the singular includes the plural and vice versa.

6.2 Severability. In the event any provision of the Plan shall be held illegal or invalid for any reason, the illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the illegal or invalid provision had not been included.

6.3 Headings not to Control. Headings and titles within the Plan are for convenience only and are not to be read as part of the text of the Plan.

6.4 Governing Law. To the extent not preempted by Federal law, the Plan, and all benefits under the Plan, shall be construed in accordance with and governed by the laws of the State of North Carolina.

6.5 Entire Plan. This document is a complete statement of the Plan. As of its Effective Date this document supersedes all prior plans, policies, guidelines, representations and proposals, written or oral, relating to the matters set forth herein. The Participating Employers shall not be bound by or liable to any person for any representation, promise or inducement made by any employee or agent of it which is not embodied in or authorized by this document or in any authorized written amendment to the Plan.

IN WITNESS WHEREOF, Bank of America Corporation has caused this instrument to be executed by its duly authorized officer this 24th day of MAY, 1999 to be effective June 1, 1999.

BANK OF AMERICA CORPORATION

By Charles J. Cooley
Charles J. Cooley
Corporate Personnel Executive

AMENDMENT TO
BANK OF AMERICA TRANSITION ASSISTANCE POLICY

Bank of America Corporation (the "Company") sponsors the Bank of America Transition Assistance Policy (the "Plan"). The Plan is a component of the Bank of America Group Benefits Program. The Corporate Personnel Executive of the Company is authorized to execute amendments to the Plan on behalf of the Company. Pursuant to such authority, the Plan is hereby amended as follows, effective as of June 1, 2001:

The name of the Plan is changed to "Bank of America Corporate Severance Program" whenever it appears.

IN WITNESS WHEREOF, Bank of America Corporation has caused this instrument to be executed by its duly authorized officer this 10th day of October, 2001.

BANK OF AMERICA CORPORATION

By 
Steele Alphin
Corporate Personnel Executive

AMENDMENT TO
BANK OF AMERICA CORPORATE SEVERANCE PROGRAM

Bank of America Corporation (the "Company") sponsors the Bank of America Corporate Severance Program (the "Plan"). The Plan is a component of the Bank of America Group Benefits Program. The Corporate Personnel Executive of the Company is authorized to execute amendments to the Plan on behalf of the Company. Pursuant to such authority, the Plan is hereby amended as follows, effective as of [January 1, 2006].

Section 3.1 of the Plan is amended by adding at the end thereof the following:

"Notwithstanding the preceding provisions of this Section, any Eligible Associate who is, at any time and from time to time, identified by the Company as a 'specified employee,' as such term is described in Section 409A(a)(2)(B)(i) of the Internal Revenue Code of 1986, as amended, shall not be eligible to participate in the Plan."

IN WITNESS WHEREOF, Bank of America Corporation has caused this instrument to be executed by its duly authorized officer this 27th day of July, 2006.

BANK OF AMERICA CORPORATION

By: *Steele Alphin*
Steele Alphin
Corporate Personnel Executive

Exhibit 6

Associate Handbook 2005



Bank of America  Higher Standards

Associate Handbook 2005

About this handbook

This Associate Handbook is generally effective January 1, 2005, except as provided below. It applies to U.S.-based associates and to global assignees whose designated home country is the United States.

The information described in the following sections applies to all associates April 1, 2005:

- "Adoption reimbursement" in the "Benefits overview" chapter
- "Short-term disability" in the "Health and wellness chapter"
- "Leaves" in the "Time away" chapter.

In addition to the above, the information on the following policies described in the "Benefits overview" chapter applies to legacy Fleet associates April 1, 2005:

- Child Care Plus
- Commuter Benefit Program
- Tuition reimbursement
- Flexible work arrangements

The "Retirement plans" chapter does not apply to legacy Fleet associates. Legacy Fleet associates who are participants in the FleetBoston Financial Savings Plan (also called the Savings Plus Plan) and the FleetBoston Financial Pension Plan, should refer to the *Reference Guide to Your FleetBoston Financial Retirement Plan Benefits 2005*, the summary plan description for those plans.

This handbook supersedes and replaces any prior communications, policies, rules, practices, standards and/or guidelines to the contrary, whether written or oral.

The provisions of this Associate Handbook do not establish enforceable employee rights, contractual or otherwise, and they do not establish an employment relationship enforceable by associates. The provisions are not promises; they are subject to change at any time without notice and are subject to management's discretion in their application. **Nothing in this handbook or any other Bank of America publication, policy or guideline shall interfere with or limit in any way the right of the company to terminate any associate's employment without cause or notice at any time, confer upon any associate any right to continue in the employ of the company, or change an associate's existing at-will employee status. Associates remain employed at will, and the at-will employment relationship can only be changed by an authorized company representative in writing.**

For convenience we use the terms "Bank of America Corporation," "Bank of America" and "company" because various companies throughout Bank of America use this handbook. The use of these terms here or in any other publication does not mean you are an employee of Bank of America Corporation. You remain solely an employee of the company that directly pays your wages.

Throughout this handbook, the term "legacy Fleet associates" refers to associates who have been subject to the personnel policies used within the former FleetBoston Financial Corporation.

Additionally, the term "former NationsBank associates" refers to associates who were subject to the personnel policies used within the former NationsBank Corporation before its merger with BankAmerica Corporation. Similarly, the term "former BankAmerica associates" refers to associates who were subject to the personnel policies used within the former BankAmerica Corporation before the merger.

Bank of America may modify, suspend or terminate any plan, program, policy or guideline described in this handbook at any time. The company also retains the discretion to interpret any terms or language used in this handbook.

If there is a discrepancy between the information in this handbook and the terms of the official plan documents, the official plan documents govern.

Leaving Bank of America
Corporate severance program

Corporate Severance Program

In today's competitive business environment, the company must often make changes to serve customers and shareholders more efficiently and effectively. Sometimes these changes can result in the loss of jobs. Generally, when this happens, the company tries to help those affected find placement opportunities within the company. If you are displaced as described below and do not locate another job within the company, you may be eligible for severance pay and other assistance to help ease the transition to employment outside the company.

Eligibility

In order to be eligible under the corporate severance program, you must be all of the following:

- In an employment classification subject to the program
- Displaced by workforce reduction, realignment or similar measure as determined by the company in its sole discretion
- Officially notified in writing of your displacement and eligibility for the corporate severance program by an authorized company representative.

Benefits

The company will determine in its sole discretion the amount, if any, of severance pay a displaced associate is eligible for and the other transition assistance that may be available.

Severance pay under the Corporate Severance Program is based on full years of service completed since your most recent hire date. If you had a break in service of less than 180 days, you will receive credit for service prior to the break.

For legacy Fleet associates, severance pay under the Separation Pay and Benefits Plan of FleetBoston Financial Corporation is based on completed continuous years of service. Partial years of service are determined in one-month increments and credited to associates as they complete each month of continuous service. If you had a break in service of less than one year, you will receive credit for service prior to the break. If your break in service is greater than one year, you may receive credit for prior service. Please contact the Personnel Service Center at **1.888.737.7661** for the determination.

If you are officially notified of your displacement, you will receive information at that time about the transition assistance that you are eligible for, including the amount of severance pay. To receive severance pay and other transition assistance, you must remain in your job until your position elimination date or last scheduled day of work determined by the company and satisfy any other conditions established by the company. You must sign, and not revoke, a general release of claims against the company, at the time and in the form specified by the company.

Severance pay and transition assistance are not provided to associates whose employment is affected by acquisitions, sales, divestitures, outsourcing, the contracting out of functions or similar events unless an authorized representative of the company specifically determines otherwise and notifies the affected associates in writing.

If the company becomes aware of facts that could have caused your immediate termination, you will lose your eligibility for transition assistance, including severance pay, and you are required to return any severance pay you have already received upon the company's request.

7. ERISA information

This chapter describes your rights under the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that governs employee benefit plans. This chapter also provides other legally required information about the Bank of America benefit plans, such as how to have your claim for benefits reviewed if you feel doing so is necessary.

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ERISA information

Overview

The provisions of the Employee Retirement Income Security Act of 1974 (ERISA) apply to many of your benefits. This federal law governs the operation of employee benefit plans. It is important that you understand some of the provisions of this law since they can affect you.

One of ERISA's requirements is that you receive an understandable description of the plan called a summary plan description. This handbook is the summary plan description for the Bank of America Group Benefits Program, an ERISA-covered employee benefits plan, which includes the following benefits:

- Medical, dental and vision coverage
- Short-term disability
- Long-term disability
- Long-term care insurance
- Associate life insurance (basic and supplemental)
- Accidental death and dismemberment (AD&D) insurance
- Dependent life insurance (spouse/domestic partner and dependent child)
- Business travel accident insurance
- Health care reimbursement account
- Dependent care reimbursement account
- Purchased time off
- Corporate severance program.

This handbook is also the summary plan description for the Bank of America Pension Plan and the Bank of America 401(k) Plan.

This "ERISA information" chapter and the "Retirement plans" chapter (except for the section entitled "Your Bank of America Pension Plan") earlier in this handbook constitute part of a prospectus covering shares of Bank of America Corporation common stock and interests in the Bank of America 401(k) Plan that have been registered under the Securities Act of 1933, as amended, for issuance under the Bank of America 401(k) Plan. The date of this prospectus is April 1, 2005.

Note to legacy Fleet associates: The information in this chapter relating to the Bank of America 401(k) and Pension Plans does not apply to you. For information about the FleetBoston Financial Savings Plus Plan and the FleetBoston Financial Pension Plan, see the summary plan descriptions for the FleetBoston Financial Savings and Pension Plans.

Your rights under ERISA

As a participant in an ERISA-covered plan, you are entitled to certain rights and protections. ERISA provides that all plan participants shall be entitled to the following:

Receiving information about your plan and benefits

As a plan participant, you can examine, without charge, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

You can examine copies of these documents in the plan administrator's office, or you can write to the plan administrator or call the Personnel Center and request that these documents be made available to you for examination.

You can also get your own copies of the documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description, by writing to the plan administrator or by calling the Personnel Center. You may have to pay a reasonable charge to cover the cost of photocopying.

You must specify the name of the plan and the particular documents in your request. See "Plan administration" later in this chapter for the appropriate address.

You automatically receive (as required by law) a summary of the plan's annual financial report.

ERISA information

Your rights under ERISA

You will automatically receive a statement about your 401(k) Plan and Pension Plan benefits after the end of each calendar quarter, including the sum of your age and benefit service and the amount of your vested benefit under each plan. You can find out how much vesting service you have through the Retirement Web site or by calling the Personnel Center.

Continuing group health plan coverage

If you are a participant in a health care plan, you can continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review the summary of the rules governing your COBRA continuation coverage rights in the "Health care benefits" section of the "Health and wellness" chapter earlier in this handbook.

While Bank of America group health care plans do not have exclusionary periods of coverage for preexisting conditions, other plans may have such provisions. Without evidence of "creditable coverage" under the Bank of America plans, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage. You should be provided a certificate of creditable coverage, free of charge, from your Bank of America group health plan when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Enforcing your rights

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from

the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the plans or exercising your rights under ERISA.

Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator by calling the Personnel Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

ERISA information

Plan administration

Plan administration

Bank of America Corporation sponsors the Bank of America Group Benefits Program, the Bank of America Pension Plan and the Bank of America 401(k) Plan. Records for the plans are kept on a calendar-year basis.

The official employer identification number assigned to Bank of America Corporation by the IRS is **56-0906609**.

The plan identification numbers assigned to the benefit plans are as follows:

- Bank of America Group Benefits Program — 501
- Bank of America Pension Plan — 001
- Bank of America 401(k) Plan — 003.

The *plan administrator* of the plans is the Bank of America Corporation Corporate Benefits Committee, which is appointed by the board of directors of Bank of America Corporation. As plan administrator, the committee is responsible for overall administration of the plans.

To contact the plan administrator, write to:

**Bank of America Corporation
Corporate Benefits Committee
Bank of America Personnel Center
NC1-003-03-30
901 W. Trade Street
Charlotte, NC 28255**

You may also call the Personnel Center at **1.800.556.6044** (legacy Fleet associates call **1.888.737.7661**) to request documents or general information. Persons who are hearing-impaired should use the TDD number: **1.888.343.0860**.

Participating employers

A complete list of Bank of America Corporation subsidiaries that participate in the plans can be obtained from the plan administrator. For convenience, these companies are frequently referred to together in this handbook as Bank of America.

An associate's participation in plans sponsored by Bank of America Corporation or the use of the term "Bank of America" or "company" does not mean that an associate is employed by Bank of America Corporation, nor does it affect an associate's legal status as an employee of a corporate subsidiary, such as Bank of America, N.A., or other Bank of America Corporation subsidiary. Each associate is employed by the entity that directly pays his or her wages.

Plan documents

Each of your ERISA-covered benefit plans is based on a plan document. This handbook is a summary of the more important plan features. You can find full details in the official plan documents. If a plan provision described in this handbook disagrees with the official plan document, the wording of the official plan document always governs. For information about how to obtain a copy of a plan document, see "Receiving information about your plan and benefits" earlier in this chapter.

Plan amendment and termination

Plan benefits of any Bank of America benefits plan are available only while the plan is effective and only pursuant to its terms. The company has the exclusive right to amend, suspend or terminate any employee benefit plan or any other program described in this handbook at any time without prior notice (except as required by law) to associates, former associates, their beneficiaries or any other person. Plan participants and beneficiaries have no vested rights in any plan or program other than in their vested accrued benefits in the Pension Plan and 401(k) Plan; in particular, no vested rights arise in those benefits currently made available to retirees after employment ends.

Special rules for acquisitions

The company may establish special eligibility rules applicable to designated acquisitions. In certain situations, the company may also grant credit for past service. Affected individuals will be notified if any of these special provisions apply.

ERISA information

Claiming your benefits

Claiming your benefits

If you think you are eligible for a certain benefit from any plan, you generally have to submit a claim to receive the benefits.

Specific instructions about submitting claims are included in each section of this handbook. Generally, claims must be submitted in writing. Often, there are time limits for submitting your claims. Make sure you know the time limits of each plan. If you delay submitting your claim, you could lose benefits. Your claim is not considered submitted until you have provided any additional documentation that is necessary for the claim.

Once your claim has been documented and you have filled out all the necessary forms, your claim generally is processed within 90 days after it is received. Special circumstances may require an extension for processing the claim. If this happens, you will be notified that additional time, not to exceed another 90 days, is required to process the claim. Disability benefit claim determinations will be made within 45 days, with two 30-day extensions permitted.

If your claim is denied, you will be notified in writing. This written notice will tell you the reason for the denial. It also will point out what additional information is needed, if any, that could change the decision to deny the claim. Finally, the notice will tell you how you can have the decision reviewed.

Review procedure

If your claim has been denied, you or your authorized representative can request to have the decision on your claim reviewed. You have 90 days (180 days in the case of disability benefit claims) from the time you're notified of the denial of your claim to request review. You may also appeal any other decision concerning your participation in the plans.

Your request for review of the decision must be in writing. You should state that you are requesting the review and describe the decision you are requesting to be reviewed. Although you are not required to do so, your request for review should state the reasons why you think the decision on the claim was incorrect.

Requests to review denied claims (appeals) for group health care plans, short-term disability, and all insured benefits under the Group Benefits Program should be directed to the insurance company or service provider that insures or administers the plan at the address listed on the notice of claim denial. The Bank of America Benefits Appeals Committee reviews appeals of denied claims for the other benefits under the Group Benefits Program and for the Pension Plan and 401(k) Plan. The Bank of America Corporation Corporate Benefits Committee, as plan administrator, has delegated to the Benefits Appeals Committee and insurance companies or service providers described in this paragraph, discretionary authority to determine eligibility for benefits and construe the terms of the applicable plan and resolve all questions relating to claims for benefits under the plan.

The mailing address for the Benefits Appeals Committee is:

Bank of America Benefits Appeals Committee
Bank of America Personnel Center
NC1-003-03-30
901 W. Trade Street
Charlotte, NC 28255

Telephone number: Personnel Center at **1.800.556.6044**. Persons who are hearing-impaired should use their local Relay service.

You or your authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information related to your claim.

A decision on your request for review will ordinarily be made within 60 days (or within 120 days if special circumstances require an extension). If no decision is made within 120 days, the claim is considered denied on review. The final decision will be sent to you in writing, together with an explanation of how the decision was made. For disability benefit appeals, a decision will be made within 45 days, with one additional 45-day extension permitted.

Unless you have exhausted your administrative review rights under the plan, you generally are prohibited from bringing a civil action against the plan for benefits.

If the plan provides for binding arbitration of any controversy between a plan participant or beneficiary and the plan, including, as applicable, its agents, employees, providers and staff physicians, then any such controversy is subject to binding arbitration.

Health plans claim and review time limits

Special timeframes apply to claims filed and requests for review under the Bank of America health plans.

Notification of initial determination

After you make your claim for benefits in accordance with plan procedures, the following time limits apply:

- If your claim involves *urgent care*, you will be notified of the plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the plan.

If the plan is not provided sufficient information to make a decision, you will be notified as soon as possible, but not later than 24 hours after receipt of the claim. You would then have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the needed information. The plan will notify you of its benefit determination as soon as possible, but generally not later than 48 hours after the plan's receipt of the information.

- If the plan has previously approved an *ongoing course of treatment* to be provided over a period of time or number of treatments, you will be notified of any reduction or termination of the course of treatment in sufficient time before the end of the approved course of treatment to allow you to appeal the benefit determination. If you request an extension of the course of treatment beyond the approved period of time or number of treatments and the claim involves *urgent care*, the plan will make a determination as soon as possible, and you will be notified of the benefit determination within 24 hours (provided you make the request at least 24 hours prior to the end of the course of treatment).

- If you have a *pre-service claim* (other than for *urgent care* or *ongoing care*), you will be notified of the plan's benefit determination not later than 15 days after receipt of the claim by the plan. A *pre-service claim* is one in which the plan conditions the receipt of benefits, in whole or part, on approval of the benefit in advance of obtaining medical care.

The plan may extend this period for up to 15 days, if necessary due to matters beyond the control of the plan. You will be notified if this occurs. If the extension is necessary due to your failure to submit enough information, you will have at least 45 days to submit the needed information.

If you fail to follow plan procedures for filing a *pre-service claim*, you will be notified as soon as possible, but not later than five days (24 hours in the case of a failure to file a claim involving *urgent care*).

- If you have a *post-service claim*, you will be notified of the plan's benefit determination within 30 days after receipt of the claim. The plan may extend this period for up to 15 days, if necessary due to matters beyond the control of the plan. You will be notified if this occurs. If the extension is necessary due to your failure to submit enough information, you will have at least 45 days to submit the needed information.

Request for review

If you receive an adverse benefit determination, you will have 180 days to request a review of the decision.

- If your claim involves *urgent care*, you can request an expedited appeal of an adverse benefit determination orally or in writing. You will be provided all necessary information by telephone, facsimile, or other available expeditious method.

You will be notified of the plan's benefit determination on review not later than 72 hours after receipt of request for review.

- If you have a *pre-service claim*, you will be notified of the plan's benefit determination on review within 30 days if the plan provides for only one appeal of an adverse benefit determination or within 15 days for each appeal if the plan provides for two appeals of an adverse determination.
- If you have a *post-service claim*, you will be notified of the plan's benefit determination on review within 60 days if the plan provides for only one appeal of an adverse benefit determination or within 30 days for each appeal if the plan provides for two appeals of an adverse determination.

Agent for legal process for ERISA-covered plans

The agent for service of legal process for the ERISA-covered plans is the Bank of America Corporation Corporate Benefits Committee as plan administrator. Legal process also may be made on the appropriate plan trustee or insurance company at the address shown in **Figure 7.1**.

ERISA information

ERISA-covered plans

ERISA-covered plans

Bank of America Corporation sponsors each ERISA-covered plan listed in **Figure 7.1**.

Figure 7.1**ERISA-covered plans**

Plan number	Plan name	Plan type	Contributions and funding	Payment of benefits	Plan trustee, insurer or service provider
001	Bank of America Pension Plan	Defined benefit plan (retirement); funding of company-provided benefits for retirees under the Bank of America Group Benefits Program (welfare)	Company contributions based on actuarial determination	Paid from trust	Bank of America, N.A., Trustee TX4-213-06-04 PO Box 2518 Houston, TX 77252-2518
003	Bank of America 401(k) Plan	Defined contribution plan (retirement)	Pre-tax associate contributions; company match based on plan formula	Paid from trust	Bank of America, N.A., Trustee under Principal Trust Agreement TX4-213-06-04 PO Box 2518 Houston, TX 77252-2518 State Street Bank and Trust Company, Trustee under Leveraged Trust Agreement 200 Newport Avenue North Quincy, MA 02171
501	Bank of America Group Benefits Program	Health and welfare benefit plans	See below	See below	Bank of America, N.A., Trustee TX4-213-06-04 PO Box 2518 Houston, TX 77252-2518
	Aetna Select EPO/Aetna Choice II PPO	Hospitalization and medical benefits	Not insured; company and associates share costs based on actuarial determination; associate portion is before-tax	Service provider	Aetna 11675 Great Oaks Way 3rd Floor Alpharetta, GA 30022

ERISA information

ERISA-covered plans

ERISA-covered plans

Plan number	Plan name	Plan type	Contributions and funding	Payment of benefits	Plan trustee, insurer or service provider
501 <i>(continued)</i>	<ul style="list-style-type: none"> • Blue Choice HMO Georgia • Blue Cross Blue Shield EPO • Blue Cross Blue Shield PPO • Blue Cross California PPO • Blue Cross California Out-of-Area • Blue Cross California High Deductible Plan • Blue Cross Blue Shield Out-of-Area Plan • Blue Cross Blue Shield High Deductible Plan 	Hospitalization and medical benefits	Not insured; company and associates share costs based on actuarial determination; associate portion is before-tax	Service provider	Blue Cross Blue Shield of Georgia PO Box 7368 Columbus, GA 31908
	Blue Cross Blue Shield Florida (Health Options —BlueCare HMO)				Health Options, Inc. PO Box 1798 Jacksonville, FL 32231
	CIGNA Open Access HMO				CIGNA Healthcare 10490 Little Patuxent Parkway 60 Corporate Center, Suite 400 Columbia, MD 21044
	Companion HealthCare HMO (South Carolina)				BCBS of South Carolina PO Box 6170 Columbia, SC 29260-6170
	Harvard Pilgrim HMO				Harvard Pilgrim Health Care 93 Worcester Street Wellesley, MA 02481
	Independent Health EPO				Independent Health 511 Farber Lakes Drive Buffalo, NY 14221
	MVP Select Care HMO				MVP Select Care, Inc. 625 State Street Schenectady, NY 12305

ERISA information

Overview

ERISA-covered plans					
Plan number	Plan name	Plan type	Contributions and funding	Payment of benefits	Plan trustee, insurer or service provider
501 (continued)	Optima Health HMO Virginia	Hospitalization and medical benefits	Not insured; company and associates share costs based on actuarial determination; associate portion is before-tax	Service provider	Optima Health Plan 4417 Corporation Lane Virginia Beach, VA 23462
	Premera Blue Cross Foundation EPO				Premera Blue Cross 7001 220th Street SW Building 3 Mountlake Terrace, WA 98043-2124
	Presbyterian EPO New Mexico				Presbyterian Health Plan 2501 Buena Vista SE PO Box 27489 Albuquerque, NM 87125-7489
	Tufts Health Plan Open Access EPO				Tufts Health Plan 333 Wyman Street Waltham, MA 02454
	United Choice EPO				UnitedHealthcare PO Box 740800 Atlanta, GA 30374-0800
	Caremark				Caremark PO Box 52116 Phoenix, AZ 85072-2116
	CIGNA Behavioral Health				CIGNA Behavioral Health 11095 Viking Drive Suite 350 Eden Prairie, MN 55344
	Regional HMOs/EPOs (other than those listed above)			Services provided directly by HMO/EPO	Blue Shield of California 50 Beale Street San Francisco, CA 94105
	Blue Shield HMO Access + Northern and Southern California				BCBS of Illinois 1020 West 31st Street Downers Grove, IL 60515
	Blue Cross Blue Shield HMO Illinois				BCBS – Capital Health Plan PO Box 15349 Tallahassee, FL 32317-5349
	Capital Health HMO Tallahassee				Group Health Cooperative 521 Wall Street Seattle, WA 98121-1524
	Group Health Co-op East and West				Health Plan of Nevada, Inc. PO Box 15645 Las Vegas, NV 89114-5645
	Health Plan Nevada HMO				

ERISA information

ERISA-covered plans

ERISA-covered plans

Plan number	Plan name	Plan type	Contributions and funding	Payment of benefits	Plan trustee, insurer or service provider
501 (continued)	HealthNet HMO Northern and Southern California	Hospitalization and medical benefits	Insured; company and associates share cost of insurance premiums; associate portion is before-tax	Services provided directly by HMO/EPO	Health Net of California PO Box 10348 Van Nuys, CA 91410-0348
	HMSA Hawaii PPO				BCBS of Hawaii PO Box 860 96808-0860
	Kaiser plans, including: • Kaiser HMO Georgia and (CCO) • Kaiser HMO Hawaii • Kaiser HMO Mid-Atlantic • Kaiser HMO Northwest • Kaiser Northern and Southern California				Kaiser Permanente One Kaiser Plaza Oakland, CA 94612
	Scott & White HMO				Scott & White Health Plan 2401 South 31st Street Temple, TX 76508-3000
	MetLife Dental Plan (preferred provider organizations)	Dental benefits	Insured; company and associates share cost of insurance premiums; associate portion is before-tax	Insurer	Metropolitan Life Insurance Co. One Madison Avenue New York, NY 10010
	Aetna Dental Maintenance Organization (DMO)	Dental benefits	Insured; company and associates share cost of insurance premiums; associate portion is before-tax	Services provided directly by DMO	Aetna 11675 Great Oaks Way 3rd Floor Alpharetta, GA 30022
	Vision plans (preferred provider organizations)	Vision benefits	Insured; associates pay insurance premiums on before-tax basis	Insurer	Cole Managed Vision 1925 Enterprise Parkway Twinsburg, Ohio 44087 Vision Service Plan (VSP) Customer Service PO Box 997100 Sacramento, CA 95899-7100 VisionCare Plan (A CompBenefits Company) 1511 N. Westshore Suite 1000 Tampa, FL 33607-4591

ERISA Information

ERISA-covered plans

ERISA-covered plans

Plan number	Plan name	Plan type	Contributions and funding	Payment of benefits	Plan trustee, insurer or service provider
501 (continued)	Associate life insurance – basic	Life insurance	Company pays insurance premiums	Insurer	Metropolitan Life Insurance Co. One Madison Avenue New York, NY 10010
	Associate life insurance – supplemental	Life insurance	Associates pay insurance premiums on after-tax basis	Insurer	Metropolitan Life Insurance Co. One Madison Avenue New York, NY 10010
	Accidental death and dismemberment (AD&D) insurance	Accident insurance	Associates pay insurance premiums on before-tax basis	Insurer	Metropolitan Life Insurance Co. One Madison Avenue New York, NY 10010
	Business travel accident insurance	Travel accident insurance	Company pays insurance premiums	Insurer	Chubb Group Suite 900 3445 Peachtree Road NE Atlanta, GA 30326-1276
	Dependent life insurance – spouse/domestic partner and dependent child	Life insurance	Associates pay insurance premiums on after-tax basis	Insurer	Metropolitan Life Insurance Co. One Madison Avenue New York, NY 10010
	Health care and dependent care reimbursement accounts	Health care and dependent care expense reimbursement	Unfunded; associates make before-tax contributions	Service provider	WageWorks Processing Center 4129 E. Van Buren Street Suite 220A Phoenix, AZ 85008
	Short-term disability	Disability income	Company pays cost	Paid directly by company	
	Long-term disability insurance	Disability income	Company and associates share cost of insurance premiums; associate portion is before-tax	Insurer	Metropolitan Life Insurance Co. One Madison Avenue New York, NY 10010
	Long-term care insurance	Long-term care insurance	Associates pay insurance premiums on after-tax basis	Insurer	John Hancock Life Insurance Co. PO Box 111 Boston, MA 02117-0111
	Corporate severance programs	Severance pay	Company pays cost	Paid directly by company	

Associate Handbook 2006 Addendum

~ About this addendum

There have been changes and additions to some of the information in the *Associate Handbook 2005* since it was distributed in July 2005. This addendum follows the topic and page order of the *Associate Handbook 2005*. To make it easier to follow, note the page number listed by each entry in the addendum (with the exception of the "Health care benefits" section, which contains revisions and clarifications to some of the existing benefit plans listed by state). This will be the page where the new information should be included in the *Associate Handbook*. You will need to read the appropriate pages in both the addendum and the *Associate Handbook* to be sure you have the most current information.

You will find included in this addendum:

- Revisions and clarifications to some of the company's policies, including changes to short-term disability (STD) and time away
- Revisions and clarifications to some of the existing benefit plans
- Information about claims procedure

Page 185 — The words “on severance on or before April 1, 2006” are added after “For legacy Fleet associates” in the third paragraph under the Benefits section. This change is effective April 2, 2006, and the paragraph reads:

For legacy Fleet associates on severance on or before April 1, 2006, severance pay under the Separation Pay and Benefits Plan of FleetBoston Financial Corporation is based on completed continuous years of service. Partial years of service are determined in one-month increments and credited to associates as they complete each month of continuous service. If you had a break in service of less than one year, you will receive credit for service prior to the break. If your break in service is greater than one year, you may receive credit for prior service. Please contact the Personnel Center at **1.800.556.6044** for the determination.

CHAPTER 7 — ERISA

Review procedure

Page 192 — The following should replace the second sentence of the first paragraph under the “Review procedure” section:

You have 60 days (180 days in the case of disability benefit claims) from the time you’re notified of the denial of your claim to request review (or, if no notice of denial has been received, you have 150 days from the filing of the initial claim to request review). If you fail to file a request for review within the required time period, you are considered to have permanently waived and abandoned your claim and you may not refile it.

Page 192 — The following is added at the end of the second-to-last paragraph in the third column:

You must bring any civil action for benefits no later than one year following the final decision on your claim under these claims procedures. If you fail to bring a civil action within the required time period, you are considered to have permanently waived and abandoned your claim and you may not reassert it.

This addendum is a Summary of Material Modifications to the Bank of America benefit plans described in the *Associate Handbook* 2005, except for the Retirement Plans chapter which is now contained in a separate supplement. Except as modified in this addendum, the 2005 edition of the *Associate Handbook* remains in effect for 2006. References to the *Associate Handbook* include this addendum. The changes described in this addendum are effective as of January 1, 2006. This material, along with the *Associate Handbook*, together describe the benefit plans as revised and in effect on and after January 1, 2006.

This addendum supersedes and replaces any prior communications, policies, rules, practices, standards and/or guidelines to the contrary, whether written or oral.

For convenience, we use the terms "Bank of America Corporation," "Bank of America" and "company," because various

companies throughout Bank of America use this addendum and the *Associate Handbook*. The use of these terms in these materials or in any other publication does not mean you are an employee or retiree of Bank of America Corporation.

Bank of America may modify, suspend or terminate any plan, program, policy or guideline described in this addendum or the *Associate Handbook* at any time. The company also retains the discretion to interpret any terms or language used in this addendum or the *Associate Handbook*.

If there is a discrepancy between the information in this addendum or the *Associate Handbook* and the terms of the official plan documents, the official plan documents govern.

Please keep this addendum with your other Bank of America benefit plan materials so that you have up-to-date information on your benefit plans.

Exhibit 7

Your Benefits Handbook

Summary Plan Descriptions

Medical Plan

For information on...	See page...
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Plan Overview

Your medical benefits encourage cost-conscious health care choices and emphasize preventive care. ABN AMRO believes that proper medical care is important – and that having choices in coverage makes good sense.

Plan-at-a-Glance

The Company gives you three Managed Choice Medical Options from which to choose. Each of these three Options is a part of the ABN AMRO Group Welfare Plan (Medical), commonly referred to as the ABN AMRO Group Medical Plan (the “Medical Plan,” the “Managed Choice Medical Plan” or, in this portion of the Summary Plan Description, the “Plan”)-Option I and Option II are a self-insured arrangement. Option III is a fully-insured program.

Option I: PPO – Through the Preferred Provider Organization Plan, each time you need care, you can choose to receive “network” care or “out-of-network” care. You choose from a comprehensive list of network physicians. This list can be obtained, without charge, in a separate document or via the vendor’s website.

Receiving care from your in network physician results in a higher benefit level. If you choose to receive out-of-network care, your benefits are paid at a lower level.

Option II: Select Network Plan (EPO) – The Select Network (EPO) allows you to receive care from any in network provider. Your benefit level is generally higher than the PPO Plan. You are not allowed to go out of network.

Option III: PHP HMO – You may be eligible to enroll in the PHP Health Maintenance Organization (an “HMO”) if you live in certain areas of Michigan. An HMO is a prepaid, insured health care plan that delivers comprehensive medical services for a fixed monthly fee and, in most cases, without a deductible. In an HMO, you use doctors and medical facilities connected with the HMO. Care not authorized by the HMO is not covered. Details regarding coverage under an applicable HMO are contained in the certificate, summary or other applicable insurance document prepared by, or on behalf of, the HMO (the “HMO Document”). Such detailed information with respect to HMO coverage is not included in this Handbook.

The following benefits chart provides a quick overview of generally available medical benefits under Options I and II. Details of these medical benefits and the Plan options follow.

The following benefit levels under the PPO Plan is for medically necessary covered charges that are considered usual and customary. Annual and lifetime maximums apply to certain services. (See “Services with Annual Maximums” and “Lifetime Maximum” sections for details.)

Rates of Reimbursement and Other Important Information

	Option I: PPO		Option II:EPO
Plan Provision/Service	Network	Out-of-Network	In network only
Annual Deductible	\$150/individual \$450/family	\$250/individual \$750/family	None None
Annual Out-of-Pocket Maximum	\$1,500/individual \$3,000/family	\$2,500/individual \$5,000/family	None None
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Doctor's Office Visits	Plan pays 100% after \$15 co-payment. Specialist has a \$25 co-payment. Plan pays 90% for all other services after deductible	70% after deductible	100% after \$20 office copay. Specialist 100% after \$30 copay
Physician Hospital Charges	90% after deductible	70% after deductible	100%
Hospital Care	90% after deductible	70% after deductible	100%
Hospital Room and Board	90% after deductible	70% after deductible	100% after \$250 per confinement copay
Urgent Care	100% after \$50 copay	100% after \$50 copay	100% after \$50 copay
Emergency Room Care	100% after \$100 co-payment (copayment waived if admitted)	100% after \$100 copay (copay waived if admitted)	100% after \$100 copay (copay waived if admitted)
Maternity Office Visits	100% after \$15 co-payment	70% after deductible	100% after \$20 copay
Gynecological Exam (including Pap smear)	100% after \$15 co-payment	70% after deductible	100% after \$20 copay
Mammograms	100% no deductible (routine) 90% after deductible (outpatient diagnostic)	70% after deductible	100%
Immunizations	100% after \$15 co-payment	70% after deductible	100% after \$20 copay
Routine Annual Physicals	100%, after \$15 co-payment	70% after deductible	100% after \$20 copay
Wellness Care Benefit Maximum	Does not apply	\$500 maximum per year	Does not apply
Surgery (inpatient and outpatient)	90% after deductible	70% after deductible	100%
Mental Health and Substance Abuse Treatment	Outpatient-90% after \$25 co-payment (up to 25 visits/yr) Inpatient-90% after deductible (up to 30 days/yr)	Outpatient-70% after deductible (up to 25 visits/yr) Inpatient-70% after deductible for hospital fees (up to 30 days/yr)	Outpatient-100% after \$30 copay per visit (up to 20 visits/yr) Inpatient-100% after \$250 copay (up to 20 days/yr)
Chiropractic Care	100% (after \$25 co-payment) up to \$2,500 per year	70% up to \$2,500 per year	100% after a \$30 copay up to \$2,000 per year
Home Health Care	90% after deductible (100 visits per year)	70% after deductible (100 visits per year)	100% (60 visits per year)
Hospice Care	90% after deductible (no lifetime max)	70% after deductible (no lifetime max)	100% (no lifetime max)

Hearing	90% of the Usual and Customary Fee and after deductible*; appliances covered at max benefit of \$3,000 every 36 months	Not covered	100% covered after copay*; appliances covered at max benefit of \$3,000 every 36 months
Physician Selection	You must choose a physician within the network.	You may choose any eligible physician.	You must choose an in network physician in order to receive benefits.

*Please review Covered Expenses Section beginning on Page 9 for more information

Plan Benefits

Eligibility

For You – In general, you are eligible for the health insurance coverage described in this section on the first day of the month following or coinciding with the date on which you complete 1 month of active service with an Employer (as that term is defined in the Important Plan Information section of this Handbook). “Active service” means you are working full workdays on a regular full-time basis, or you are regularly scheduled to work part-time at least 20 hours a week, within the United States (and at such other locations approved by the Employer) under the direction or control of your Employer. If such an employee is on temporary leave of absence or on temporary assignment outside of the United States (as from time to time determined by his Employer), he shall be considered in “active service.”

You may choose not to receive coverage. Generally, if you elect no medical coverage, you cannot elect coverage until the next annual enrollment period unless you have a qualifying change in status, or unless special enrollment applies. (See “Changing Your Coverage” for more information on changes in status and “Special Enrollment Periods” for more information on special enrollment rights.)

For Your Dependents – You may choose to cover your eligible dependents under the same medical option under which you are covered. Eligible dependents are your spouse and your unmarried children to age 19, if they live in the United States or Canada and are not in the military.

To be eligible for coverage, each of your children must also be living with you and dependent on you for support, or you must have a legal obligation to provide coverage. If two legally married employees are both eligible for medical coverage, they will be eligible to be enrolled together or separately as individual employees. However, they cannot both be enrolled as employee and spouse on each other’s coverage.

Coverage for an unmarried child may be extended to age 25 as long as the child (i) is a full-time student (at an approved school) who depends on you for support, and (ii) is not employed on a full-time basis.

Coverage for a disabled child may be extended beyond the otherwise applicable age limit. A “disabled child” is unable to work in self-sustaining employment on account of a physical or mental handicap or mental retardation, is chiefly dependent upon you for support, and is otherwise eligible as a dependent (except for the age limit). To be eligible for this extension, the disabled child must have been covered under the Plan on the day before the day on which he reached the age limit. Also, you must submit proof of the disabled child’s handicap to the Company within 31 days of the date on which such child’s coverage would otherwise end due to the age limit.

“Child” (or “children,” as applicable) refers only to your natural (biological) or adopted child, or your stepchild; no other category of child is eligible for coverage. Your natural child becomes eligible for coverage no earlier than such child’s birth. Your adopted child becomes eligible for coverage when there exists for such child proof, acceptable to your Employer, of legal adoption by you, or legal placement for adoption with you. A child is “placed for adoption” with you when you have assumed, and continue to retain, the legal obligation for the total or partial support of such child in anticipation of your adoption of that child. Your stepchild becomes eligible for coverage when that child becomes your dependent through your marriage to such child’s parent and there exists proof, acceptable to your

Employer, of such stepchild's dependent status. Further, unless a Qualified Medical Support Order applies, your stepchild who is an otherwise-eligible dependent under the Plan must live with you to be eligible for coverage under the Plan. Such coverage will not be provided to an otherwise-eligible stepchild who does not reside in your household at all times during the period which you have coverage under the Plan.

You may be required to submit any proof discussed above to your Employer before any applicable coverage will be extended to any child discussed above.

Domestic Partner - You may be able to purchase medical coverage for your Domestic Partner. For purposes of coverage under the Plan, a "Domestic Partner" is a person-of the same or opposite sex-who satisfies each of the following conditions:

- Is at least eighteen years old;
- Is not married to anyone;
- Lives with an ABN AMRO employee who is a participant in the Medical Plan (the "D/P Participant");
- Is in a committed and mutually-exclusive relationship with such D/P Participant and intends to continue this relationship indefinitely;
- Is not related by blood to such D/P Participant;
- Is financially interdependent with such D/P Participant;
- Is not an employee of any ABN AMRO employer; AND
- Is the only person who satisfies all of the foregoing criteria with respect to such D/P Participant.

A proper, notarized Affidavit of Domestic Partnership with respect to the applicable D/P Participant and his Domestic Partner (the "Affidavit") must be filed with Corporate Benefits as part of a D/P Participant's request to purchase medical coverage for his Domestic Partner. Ask HR can provide more details about the information to be submitted in support of the Affidavit. The Plan Administrator **will decide** whether an Affidavit is sufficient to establish Domestic Partnership status for purposes of coverage under the Medical Plan. No medical coverage will be extended to a person who is claimed as a domestic partner on an Affidavit which is rejected by the Plan Administrator or its representative.

Also, you may purchase medical coverage for a child of your Domestic Partner who is otherwise-eligible for coverage under the Medical Plan if your Domestic Partner has legal guardianship of such child. In this case, you will need to provide Corporate Benefits with copies of appropriate legal documents, acceptable to the Plan Administrator, as proof of guardianship.

PLEASE NOTE: The cost of coverage under the Medical Plan for a Domestic Partner (**and such person's child or children, as applicable**) is the exclusive responsibility of the applicable D/P Participant. The value of any medical coverage provided to a Domestic Partner (**and any children**) will be included in the applicable D/P Participant's gross income (and will be taxable to such D/P Participant), as **such persons** generally will not qualify as "dependents" under federal law. Also, **neither dental coverage nor any other rights** (for example, continuation coverage, also known as "COBRA") **or benefits** are available to a Domestic Partner **or his children**.

Enrollment

You generally have until your effective date of coverage to enroll. Your coverage will then begin when you become eligible. Generally, if you don't enroll before you become eligible, you must wait to enroll until the next annual enrollment period, unless you are otherwise eligible for special enrollment (see "Special Enrollment Periods").

You must enroll an eligible dependent either when you enroll or within 30 days of the date on which such person becomes a dependent. Generally, if you do not enroll your dependent at either of these times, you may not enroll him until the next annual enrollment period, unless such dependent is otherwise eligible for special enrollment (see

"Special Enrollment Periods"). Coverage for a dependent begins on the date on which your coverage begins or on the date on which you enroll the dependent, if later.

Special Enrollment Periods

In certain cases, you may not have to wait for the next annual enrollment period if you do not enroll when you are first eligible to do so. This section discusses those special cases.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or certain dependents for coverage, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and certain dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Special Enrollment for Loss of Other Coverage – The special enrollment period for loss of other coverage may be available to you and your dependents if certain requirements are met. You or your dependent must otherwise be eligible for health coverage. When coverage was previously declined, you or your dependent must have been covered under another group health plan or must have had other health insurance coverage.

The special enrollment rights may apply to you, your dependent, or both. If you have not previously enrolled in health coverage provided in connection with your employment with the Company, you may be eligible to enroll under these rules if you have lost other coverage. Your dependent may be eligible to enroll under these rules if such dependent has lost other coverage and you are already enrolled for coverage provided in connection with your employment with the Company. Also, both you and your dependent may be eligible to enroll for coverage under these rules if either you or your dependent has lost other coverage.

If the lost "other coverage" was COBRA continuation coverage, special enrollment can be requested only after such COBRA coverage is "exhausted." This means that you or your dependent must have continued COBRA coverage (and the applicable premiums must have been paid) for the entire period it was available to you (or your dependent) in order to be eligible for this type of special enrollment. If the lost "other coverage" was not COBRA coverage, special enrollment can be requested only after eligibility for the other coverage is lost or if employer contributions for the other coverage have stopped. A person who loses the "other coverage" because of a failure to pay the applicable premiums or for cause (such as making a fraudulent claim) will not have a special enrollment right.

Special Enrollment for New Dependents – A special enrollment period may also be available if you have a new dependent because of birth, marriage, adoption or placement for adoption. Generally, the special enrollment rules may permit:

- ✓ An eligible employee to enroll for coverage when such employee gets married or has a new child (as a result of marriage, birth, adoption or placement for adoption)
- ✓ The spouse of a covered employee to enroll for coverage separately at the time of their marriage or when a child is born, adopted or placed for adoption
- ✓ The spouse of an eligible employee to enroll for coverage together with such eligible employee when they marry or when a child is born, adopted or placed for adoption
- ✓ A child who becomes a dependent of a covered employee as a result of marriage, birth, adoption or placement for adoption to enroll for coverage when the child becomes such a dependent
- ✓ A child who becomes a dependent of an eligible employee as a result of marriage, birth, adoption or placement for adoption to enroll for coverage if the eligible employee enrolls at the same time

Please contact Ask HR if you feel that you or a dependent may be eligible for special enrollment.

Cost

The Company pays the major portion of the cost of each Managed Choice Medical Option. You pay a smaller portion of the cost of coverage through automatic payroll deductions. These deductions are made on a before-tax basis. This means that you do not pay federal, Social Security and, in most cases, state or local income taxes on the amount that is deducted from your paycheck. When you enroll, your portion of the cost of medical coverage will be communicated to you. Such portion may be adjusted annually, in response to changes in the cost of the applicable coverage.

Certificate of Creditable Coverage

The Medical Plan will typically obtain, from a certificate furnished by your prior health plan or health insurance issuer (for example, an insurance company or HMO), information about your prior health coverage (and that of your dependent(s)) for purposes of evaluating applicable prior health coverage.

A "certificate of creditable coverage" for a person generally includes, among other things, the name of the applicable prior health plan and information about the period of health coverage for the person concerned.

Group health plans and certain health insurance issuers are required to furnish such a certificate to an individual to provide documentation of the individual's prior creditable coverage. The certificate must be provided:

- ✓ Automatically, when an individual either loses applicable health coverage or becomes entitled to elect COBRA continuation coverage, and when an individual's COBRA continuation coverage stops; and
- ✓ Upon request, if such request is made no later than 24 months after the applicable health coverage ends.

If necessary, the Plan will help you obtain an applicable certificate of creditable coverage from a prior health plan or health insurance issuer. Generally, however, if you have not received, from your prior health plan or health insurance issuer, a certificate of creditable coverage, either for yourself or your dependent, you will be permitted to establish creditable coverage through other means.

Medical Options

When you enroll in Managed Choice, you will choose among the following three options:

Option I: Preferred Provider Organization (PPO) – PPO allows you to choose, each time you need care, whether you want to receive care through the PPO network or out-of-network.

When a covered service is provided or arranged in network, the Plan pays a higher benefit level. When a covered service is not provided or arranged by a Network Physician (that is, out-of-network), you will generally receive a lower benefit level.

Option II: Select Network (EPO) – The EPO Plan allows you to receive care from whichever eligible network health care provider you choose. Your benefit level is generally higher than that provided by the PPO coverage. You must remain in network as there are no out-of-network benefits with this option.

Option III: PHP HMO – You may request a separate brochure and enrollment materials at enrollment time that describe PHP benefits. HMO coverage is only briefly described later in this Summary Plan Description for the Medical Plan. Details of coverage under an HMO are described in the applicable HMO Document (that is, the certificate, summary or other applicable insurance document prepared by, or on behalf of, the applicable HMO). Such details do not appear in this Summary Plan Description for the Medical Plan, but are available by contacting PHP directly (see "Important Plan Information" section).

If you enroll in PHP HMO coverage, you may not participate simultaneously in the PPO plan, Select Network (EPO) or prescription drug program described in this Summary Plan Description for the Medical Plan.

Deductible

The deductible is an amount you are required to pay each year for covered medical expenses before your Managed Choice Medical Option begins to pay for benefits. The deductible varies between the in network and out of network options in the PPO Plan. See the boxes below. (See see the applicable HMO Document for information on current HMO deductibles.)

Please note: The deductibles shown below are the current amounts. These deductibles are subject to change annually.

PPO Deductible

Your deductible will depend on whether or not you receive care from a network provider:

- ✓ *Network care: You and each covered dependent must pay an individual deductible of \$150. The family deductible is \$450.*
- ✓ *Out-of-network: You and each covered dependent must pay an individual deductible of \$250. The family deductible is the individual deductible (\$250) times the number of covered family members. However, the family deductible will not be more than an amount which is three times the individual deductible. This means that if you have three or more family members, once three family members meet their \$250 individual deductibles, your family will have met the family deductible. Similarly, if you have just two members in your family, once those two family members both meet their \$250 individual deductibles, your family will have met the family deductible.*

Co-insurance

After you meet your annual deductible (if you have one), the Plan pays the majority of eligible expenses, but you are required to pay the balance. This balance is called your co-insurance. In general, there will be a 10% co-insurance with some services in the PPO Plan. If you receive care out-of-network, your co-insurance generally will be 30% because most services are covered at 70%.

Out-of-Pocket Maximum

Managed Choice has a feature called the out-of-pocket maximum to help contain your medical expenses. You are required to pay co-insurance only up to the out-of-pocket maximum each year. When you reach your out-of-pocket maximum, the Plan pays 100% of eligible expenses for the rest of the year, up to the lifetime maximum. The out-of-pocket maximum includes the deductible, and varies per option. See the boxes that follow for a detailed explanation of the out-of-pocket maximums.

Charges that do not count toward your out-of-pocket maximum are:

- ✓ Copays for office visits
- ✓ Coinsurance for biofeedback
- ✓ Coinsurance for mental health or substance abuse treatment or diagnosis
- ✓ Penalties related to the PPO option.
- ✓ Expenses above the usual and customary amount
- ✓ Any other expense not covered by your Managed Choice Medical Option
- ✓ Co-insurance for outpatient mental health or substance abuse treatment or diagnosis

Your out-of-pocket maximum will depend on whether or not you receive care from a network provider:

- ✓ Network: Your individual out of pocket maximum is \$1,500 per individual per year and \$3,000 annually for a family.
- ✓ Out-of-network: Your individual out-of-pocket maximum is \$2,500 per year per individual and \$5,000 annually for a family. This means that once you pay \$2,500 (or two people in your family each pay \$2,500) in out-of-pocket expenses, the medical plan will pay 100% of covered medical expenses for the rest of the calendar year.

Services with Annual Maximums

The annual maximum is the total amount the Managed Choice Medical Options will pay in benefits per calendar year. The following services are the only services with annual maximums under Managed Choice.

Eligible Expense	Annual Maximum (annual unless noted below)*
Inpatient mental health and substance abuse treatments combined	30 days PPO, 20 days EPO
Outpatient mental health and substance abuse treatments combined	25 visits PPO, 20 visits EPO
Chiropractic care/Muscle manipulations	\$2,500 for BCBSIL EPO/PPO, \$2,000 for Aetna EPO
Home Health Care	100 visits for BCBSIL EPO/PPO, 60 visits for Aetna EPO
Private duty nursing service	\$3,000 per month for BCBSIL EPO/PPO*, 70 shifts (1 shift=8 hrs) for Aetna EPO
Extended care/skilled nursing facility	120 days
Physical, occupational and speech therapy services	120 combined visits
Infertility	\$15,000 lifetime maximum*
Routine annual physicals	6 exams in the first year of a child's life, 2 exams in the second year of a child's life, 1 exam in 12 consecutive months for children aged 3 to 19 (up to 25 if a full time student) and adults
Wellness care	\$500 applies to non-participating providers (BCBSIL PPO out of network only)
Temporomandibular joint dysfunction (TMJ) and related disorders	\$2,500 lifetime maximum*
Hearing aid	\$3,000 every 36 months*
Wigs (used as a cranial prostheses when medically necessary)	\$500 lifetime maximum*

Lifetime Maximum

The lifetime maximum is the total amount the PPO Plan or Select Network (EPO) Plan will pay in benefits for any covered individual. There is an unlimited lifetime maximum for most eligible expenses under these options.

Covered Expenses

Usual and Customary Fees and Expenses

The Plan provides reimbursement only for usual and customary expenses for the covered medical care you receive. Any amount more than the usual and customary amount will not count toward your deductible or out-of-pocket maximum.

Usual and customary fees and expenses refer to the prevailing range of charges, fees and expenses charged by most providers of similar training and experience located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully. The Plan reserves the right to determine a provider's usual and customary expenses. Physicians and facilities

participating in the PPO Plan are reimbursed at contracted fee levels and are generally not subject to the "usual and customary" provision.

After an applicable annual deductible is met, your Managed Choice Medical Option will pay the covered percentage of the following covered medical expenses, based on the option you choose. (See "Rates of Reimbursement" and "Other Important Information" for a list of those percentages.) Only expenses for services deemed "medically necessary" and, when required, pre-certified are eligible for coverage. (See "What Is Medically Necessary" for a definition of what is considered medically necessary.)

- ✓ Room and board in a hospital, up to the hospital's semiprivate room rate per day (for a semiprivate or private room; if you receive care in an intensive care unit, under most circumstances the Plan will pay the actual amount charged);
- ✓ Room and board in an extended care facility, up to the facility's semiprivate room rate per day (see "What Is an External Care Facility" for more information);
- ✓ Substance abuse Residential Treatment Program. (See "What Is a Residential Treatment Program.") For all Intermediate Levels of Care (e.g., Residential, Partial Hospitalization, and Day Treatment) all benefits are paid out of the In-patient benefit using the standard substitution of benefit ratio. Residential Benefit: 1:1 trade. Partial Day Benefit: 2:1 trade;
- ✓ Other hospital services needed for medical or surgical care;
- ✓ Services of a doctor and services of a nurse, other than one who lives in your home or who is a member of your immediate family;
- ✓ Routine physical exams given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease;
- ✓ Diagnostic procedures and x-rays, x-ray or radiation treatments, oxygen and its administration, anesthetics and their administration;
- ✓ Benefits for routine, and outpatient diagnostic, mammograms will be provided at the benefit level provided in the Rates of Reimbursement section;
- ✓ Pap smears for all covered women, including office visits and lab tests made in connection with the exam;
- ✓ Prostate test and digital rectal examination;
- ✓ Bone mass measurement and osteoporosis – diagnosis and treatment;
- ✓ Diabetes self-management and training – benefits are also available for regular foot care examinations by a physician or podiatrist;
- ✓ Physical therapy – benefits will be provided when rendered by a registered professional physical therapist under the supervision of a physician. The therapy must be furnished under a written plan established by a physician and regularly reviewed by the therapist and the physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals;
- ✓ Speech therapy – benefits will be provided when these services are rendered by a licensed speech therapist or speech therapist certified by the American Speech and Hearing Association. Inpatient speech therapy benefits will be provided only if speech therapy is not the only reason for admission;
- ✓ Occupational therapy – benefits will be provided when rendered by a registered professional physical therapist under the supervision of a physician. The therapy must be furnished under a written plan established by a physician and regularly reviewed by the therapist and the physician. The plan must be established before

treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals;

- ✓ Speech, physical or occupational therapy for covered children under age five, when provided by a physician or licensed therapist to treat developmental or congenital disabilities, such as Down's syndrome, cerebral palsy, autism, hearing impairment, etc., but not limited to cleft lip and cleft palate, up to a combined total of 120 visits per year;
- ✓ Infertility coverage related to the diagnosis and/or treatment of infertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intra-fallopian tube transfer and low tubal ovum transfer;
- ✓ Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:
 - You have been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments; and
 - You have not undergone four (4) completed oocyte retrievals, except that if a live birth followed a complete oocyte retrieval, two (2) more completed oocyte retrievals shall be covered.
- ✓ Well-baby and well-child care for all covered children until age six (well-baby and well-child care includes immunizations and office visits made in connection with the routine procedures; physicals required for participation in a sports activity are not included in well-baby or well-child care);
- ✓ Drugs and medicines prescribed by a doctor during inpatient care only (see "Prescription Drug Program" for information on all mail service or retail prescriptions);
- ✓ Allergy injections and allergy surveys;
- ✓ Blood transfusions, including the cost of blood, and blood plasma;
- ✓ Rental or purchase (whichever is less expensive) of durable medical equipment used for therapeutic purposes;
- ✓ Local professional ambulance service in medical emergencies;
- ✓ Outpatient surgical charges, including:
 - doctor's fees for surgery and assisting in surgery,
 - fees for administering general anesthesia, and
 - all related services and supplies provided by a hospital's outpatient department or an ambulatory surgical center;
- ✓ Hyperalimentation or total parenteral nutrition (TPN) when recovering from or preparing for surgery;
- ✓ Acupuncture treatment performed by an M.D. or D.O. (BCBSIL only, Aetna does not cover this treatment unless it's used for anesthetic purposes);
- ✓ Routine nursery and pediatric care of a newborn child;
- ✓ Mantoux test for tuberculosis screening;
- ✓ Home Health Care (for more information on what Home Health Care includes, see "What's Home Health Care and What Does It Include");
- ✓ Private Duty Nursing Service;

- ✓ Care received in a skilled nursing facility;
- ✓ Initial purchase or required replacement of artificial limbs or eyes if your loss was a result of an accidental injury or surgical procedure performed while covered under an ABN AMRO medical insurance plan;
- ✓ Medical supplies required for your treatment;
- ✓ Physiotherapy performed by a licensed physiotherapist;
- ✓ First pair of prescribed eyeglasses or contact lenses due to a cataract operation;
- ✓ BCBSIL - Hearing care coverage is provided for audiometric examination, hearing aid evaluation, conformity evaluation and hearing aids in network coverage only. Benefits are limited to one coverage service of each type in a 36 month period.
- ✓ Aetna – hearing care coverage is provided for audiometric examination performed by an otolaryngologist or otologist once in a 24 month period; appliances covered at max benefit of \$3,000 every 36 months;
- ✓ Treatment of a cyst which is not a result of an infection of the teeth or gums;
- ✓ Diagnosis and treatment of temporomandibular joint dysfunction (TMJ) and related disorders;
- ✓ Vasectomy or tubal ligation for voluntary sterilization, however, not for a reversal;
- ✓ Wigs – for use as a cranial prostheses when medically necessary;
- ✓ Transportation by railroad or scheduled commercial airline to a hospital equipped to furnish special treatment for an injury or illness;
- ✓ BCBSIL Chiropractic Services - manipulative (adjustive) treatment or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine;
- ✓ Aetna Chiropractic Services - treatment or diagnostic services rendered or prescribed by a doctor for care of spinal conditions due to structural imbalance, distortion or subluxation;
- ✓ Treatment or diagnostic services for:
 - substance abuse, including biofeedback (regardless of diagnosis) treated on an outpatient basis through a substance abuse treatment facility, or
 - substance abuse treated on an inpatient basis at a substance abuse treatment facility; and
- ✓ Treatment or diagnostic services for:
 - mental, nervous or emotional disorders, including biofeedback (regardless of diagnosis) treated on an outpatient basis, or
 - mental, nervous or emotional disorders treated on an inpatient basis (see "Services With Annual Maximums" for details about coverage limits for mental health care and substance abuse treatments).

Expenses Not Covered

The PPO and EPO Plans will not pay for any expenses for the following:

- ✓ Services or supplies provided either before coverage began under the applicable Managed Choice Medical Option or after coverage has ended (except as specifically indicated to the contrary in this Summary Plan Description) under such Managed Choice Medical Option;
- ✓ Cosmetic surgery or treatment, unless such surgery or treatment is otherwise a covered medical expense (1) needed to correct damage caused by an accident which occurred while coverage was in effect, or (2) for reconstructive surgery due to a congenital defect or birth abnormality. "Cosmetic" is defined as those procedures or services that affect appearance only, or which are preformed for a purely superficial benefit.
- ✓ Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye Radial keratotomy, an operation to correct nearsightedness;
- ✓ Lasik Eye Surgery.
- ✓ Prescription drugs received while not hospitalized (if otherwise eligible, such drugs generally will be paid through the prescription drug program);
- ✓ Routine physical exams (except as specified under "Covered Expenses");
- ✓ Services or supplies for an occupational injury or occupational sickness;
- ✓ Services or supplies that, in terms of generally accepted medical standards, are investigational or experimental. A service or supply is considered experimental or investigational if:
 - FDA approval is required for the service or supply to be lawfully marketed, and approval had not been granted at the time the service or supply was rendered; or
 - authoritative medical or scientific literature published in the United States demonstrates that medical experts either classify the service or supply as investigational, or indicate that more research is necessary before the service or supply could be classified

(Please note that more definitions for experimental or investigational exist, and that you should contact the Claims Administrator if your doctor prescribes a service or supply that might be considered experimental or investigational.);

- ✓ Services or supplies provided under any other plan that LaSalle Bank Corporation sponsors or to which LaSalle Bank Corporation contributes;
- ✓ Custodial care or care not medically necessary;
- ✓ Inpatient Private Duty Nursing Service;
- ✓ Services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental illness;
- ✓ Treatment of a self-inflicted injury or related condition;
- ✓ Charges for failure to keep a scheduled visit, after hours charges or charges for completion of a claim form;
- ✓ Services or supplies not listed under covered expenses;
- ✓ Services or supplies for which you normally would not have to pay;

- ✓ Services related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures (except as specified under "Covered Expenses");
- ✓ Operations to improve or restore sexual function or to change gender;
- ✓ Reversal of sterilization or birth control procedures;
- ✓ Education or training;
- ✓ Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot;
- ✓ Routine foot care, except for persons diagnosed with diabetes;
- ✓ Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of the disease or injury;
- ✓ Maintenance care;
- ✓ Maintenance occupational therapy, maintenance physical therapy and maintenance speech therapy;
- ✓ Speech therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation except for dependent children under the age 5;
- ✓ Weight control services including: surgical procedures; medical treatments; weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions;
- ✓ Food supplements; including infant formula purchased with or without a doctor's prescription;
- ✓ Growth hormone;
- ✓ Acupressure, aromatherapy, hypnotism, massage therapy, rolfing and other alternative treatments;
- ✓ Usual and normal home medical supplies or first-aid items;
- ✓ Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones;
- ✓ Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants (except as specified under "Covered Expenses"); or
- ✓ Services or supplies provided by a Christian Science practitioner.

Q. *What Is Home Health Care and What Does it Include?*

A. Home Health Care refers to medical assistance that a covered individual may, under certain circumstances, receive at home while recuperating from an illness.

After you meet any applicable annual deductible, your Managed Choice Medical Option may pay a percentage of covered expenses for home health care services, based on the option you choose. To qualify as home health care, such care must be provided from a hospital or other institution licensed or certified to provide home health care services. For you to be eligible to receive benefits, your doctor must submit a treatment plan to your

insurance provider (BCBSIL or Aetna) every 30 days to certify that home health care needs to be continued instead of hospital care.

Home health care includes:

- Visits for part-time or occasional home nursing care by or under the guidance of a nurse (four hours of service are considered one visit)
- Visits for part-time or occasional home health aide services given mainly for your care
- Visits for physical, occupational and speech therapy given by the home health care agency
- Medical supplies, drugs, medicines and lab services, as long as they are under the "Covered Expenses" list.

Home health care does not include:

- Services or supplies that, in terms of generally accepted medical standards, are experimental or not medically necessary
- Services or supplies for benefits that are payable under other provisions of this Plan
- Services or supplies that are not part of the home health care plan
- Services provided by a family member or a person living in your home
- Custodial care

Q. What Is an Extended Care/Skilled Nursing Facility?

A. Generally, an extended care facility, or skilled nursing facility, is a specially qualified facility that has the staff and equipment to provide skilled nursing care or rehabilitation services and other health-related services. Please note that, since other restrictions apply to this definition, not all facilities which provide such care or services will qualify as "extended care facilities" under the Plan.

Q. What Services Are Covered for Extended Care/Skilled Nursing Facility?

A. Extended care services that are covered include a semi-private room; meals, including special diets; regular nursing care; rehabilitation services such as physical, occupational and speech therapy; drugs and medicines furnished by the facility; blood transfusions; medical supplies and use of durable medical equipment.

Q. Are There Limits to Care Under the Extended Care/Skilled Nursing Facility Provision?

A. The Plan provides for up to 120 days per year.

Q. What is a Residential Treatment Program?

A. A Residential treatment program is a 24-hour group living environment. The program offers room and board and provides for or arranges for the provision of specialized treatment, rehabilitation or habilitation services for persons with emotional, psychological, developmental or behavioral dysfunctions, impairments, or chemical dependencies. The clinical criteria for admission to a Substance Abuse Residential program are:

I. Any one of the following:

1. History of continued and severe substance abuse despite appropriate motivation and treatment in an intensive outpatient or partial hospital program within the previous 3 months.
2. Risk of harm to self or others and/or pervasive impairment in functioning due to continued and severe substance use which prohibits treatment from occurring safely in a less restrictive environment.

3. The risk of exacerbation of serious concomitant medical conditions due to continued substance use, which prohibits treatment from occurring safely at a lower level of care and requires 24-hour monitoring.
4. Risk of withdrawal symptoms, which cannot be safely managed without requiring 24-hour monitoring
5. A living environment that is subversive to abstinence, and a high risk of substance induced dangerous behavior.
6. Withdrawal symptoms of extreme subjective severity with the lack of resources or functional social supports to manage the symptoms.

II. And all of the following:

1. The patient must also be stable from a medical and psychiatric standpoint to be able to participate in a 24-hour structure milieu.
2. Have a treatment plan in place that includes family participation and/or social support network if clinically appropriate and support groups.
3. Treatment is not solely for the following: antisocial behavior, legal, or occupational (school) problems.
4. Patient refusal to comply with treatment at a less restrictive level of care.
5. Used as a substitute for other available community resources.
6. Used as a substitute for focused ambulatory treatment of relapse.

Q. What Is Custodial Care?

A. Any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating dressing, etc.). Custodial Care also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you. Custodial services and supplies are not covered under the medical plans.

Q. What Is "Medically Necessary"?

A. The Medical Plan pays up to the usual and customary amount for "medically necessary" services or supplies. What exactly does this mean? To be medically necessary, the service or supply must meet all of the following conditions:

- Is not purely educational or experimental;
- Is appropriate and necessary for, and consistent with, the symptoms or diagnosis and the treatment or distinct improvement of an illness or injury;
- Conforms with the standards of good medical practice that are uniformly recognized and professionally endorsed by the general medical community at the time the service or supply is provided;
- Is not mainly for the convenience of the patient, doctor or other provider; and
- Is the most appropriate medical service, supply or level of care that can safely be provided.

The Claims Administrator determines what is medically necessary by:

- Reviewing documented medical literature;
- Analyzing results of any tests performed to consider conclusions reached by regulatory or medical organizations;
- Consulting other physicians who have expertise in that particular field;
- Employing any other appropriate means or method.

Maternity Service

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for covered services received in connection with both normal pregnancy and complications of pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have individual coverage. These covered services are: a) the routine inpatient hospital nursery charges and b) one routine inpatient examination and c) one inpatient hearing screening as long as this examination is rendered by a physician other than the physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if your newborn has coverage. You may apply for coverage to add your newborn within 30 days of date of the birth. Your newborn's coverage will then be effective from the date of the birth.)

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your provider will be required to obtain authorization from the claim administrator for prescribing a length of stay more than 48 hours (or 96 hours).

Special Medical Plan Features

Pre-certification

The PPO and EPO Plans include a pre-certification program sponsored by your insurance provider (BCBSIL or Aetna). Pre- certification is designed to help you receive the most appropriate health care when you or an eligible dependent is hospitalized.

Before you call your insurance provider (BCBSIL or Aetna), have the following information available:

- The patient's name and Social Security number,
- The patient's address,
- The doctor's name and telephone number,
- The name of the hospital and proposed date of admission, and
- Information on the patient's medical condition.

When You Must Call – You (or a doctor or family member) must call your insurance provider (BCBSIL or Aetna) at the following times:

- Before a nonemergency hospital admission,
- Within 48 hours of an emergency admission,
- Prior to the start of Private Duty Nursing services,

- ✓ Prior to the start of Home Health Care services and
- ✓ Prior to the admission to a Skilled Nursing Facility.

If you are physically unable to make the call – for example, if you are unconscious – a family member or the hospital may make the call.

What Happens When You Call – When you call your insurance provider (BCBSIL or Aetna), you'll talk to a health care professional who will request information about your condition and the hospitalization. Your insurance provider (BCBSIL or Aetna) will then call your doctor to discuss the case. If you are admitted to the hospital, your insurance provider (BCBSIL or Aetna) will monitor your length of stay. If you are not discharged as originally intended, your insurance provider (BCBSIL or Aetna) will consult with your doctor about the medical necessity of extending your stay.

What Happens if You Don't Call – If you don't call your insurance provider (BCBSIL or Aetna) when required, you will be charged a \$500 penalty. The penalty will not count toward your deductible or out-of-pocket maximum.

The Number to Call – Call your insurance provider (BCBSIL or Aetna). The telephone number is printed on your insurance ID card.

Special Note

Remember, you are responsible for ensuring that your insurance provider (BCBSIL or Aetna) is called by you, a doctor or family member, in case of an emergency.

Information About Emergencies and Urgent Care Centers

The need for urgent care is defined as a sudden illness, injury or condition that:

- ✓ *Is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health,*
- ✓ *Includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment,*
- ✓ *Does not require the level of care provided in the emergency room of a hospital; and*
- ✓ *Requires the immediate outpatient medical care that cannot be postponed until the covered person's physician becomes reasonably available.*

Information About Emergencies and the "ER"

An emergency is defined as the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences. If you have an emergency, find help immediately from the nearest doctor or facility, and then call your insurance provider (BCBSIL or Aetna) within 48 hours of such admission.

What constitutes an emergency? Emergencies include:

- ✓ *Excessive bleeding,*
- ✓ *Loss of consciousness,*
- ✓ *Severe chest pain,*
- ✓ *Inability to breathe,*
- ✓ *Broken bones, and*
- ✓ *Illness or injury that could cause permanent damage to bodily functions.*

Emergency rooms are sometimes used by people who can't find a doctor at night or who don't know where else to turn. Using an emergency room for nonemergencies can mean long waits, a different doctor each time, no follow-up evaluations – and higher costs. You should be aware that, if you use an emergency room for a nonemergency without authorization from your Primary Care Physician, the Plan will generally pay otherwise-covered charges based on the out-of-network rate only. Be sure to use the emergency room only for emergencies such as those listed above.

National Medical Excellence Program (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that cannot be provided within an NME Patient's local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, the Plan will pay a benefit for Travel and Lodging expenses, but only to the extent described below:

Travel Expenses

These are expenses incurred by an NME Patient for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment. Also included are expenses incurred by a Companion for transportation when traveling to and from an NME Patient's home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an NME Patient for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum of \$50.00 per person per night.

Also included are expenses incurred by a Companion for lodging away from home:

- while traveling with an NME Patient between the NME Patient's home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the Companion's presence is required to enable an NME Patient to receive such services from the Medical Facility on an inpatient or outpatient basis.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a hospital or other temporary residence from which an NME patient travels in order to begin a period of treatment at the medical facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the NME patient's home.

Travel and Lodging Benefit Maximum

For all travel expenses and lodging expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the travel and lodging maximums per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an NME patient and ends on the earlier to occur of:
 - One year after the day the procedure is performed; and
 - The date the NME patient ceases to receive any services from the facility in connection with the procedure.

Limitations

Travel expenses and lodging expenses do not include, and no benefits are payable for, any charges which are included as covered medical expenses under any other part of the Plan.

Travel expenses do not include expenses incurred by more than one companion who is traveling with the NME patient.

Lodging expenses do not include expenses incurred by more than one companion per night.

Prescription Drug Program

If you enroll in the PPO or EPO Plan, you may participate in the prescription drug program through Express Scripts, Inc.. This program is not available if you choose coverage under an HMO. Please refer to HMO certificate for prescription drug coverage information. The prescription drug program is designed to help control prices while offering you quality products and dependable services. You can purchase prescriptions through a participating network of retail pharmacies and through a mail service – both with no deductible. Refer to your enrollment materials for more information on these services.

Prescription Drug Benefit

	You Pay	Your Minimum Payment	Your Maximum Payment
Retail (up to a 30-day supply)			
Generic	25%	\$5	\$75
Formulary Brand	25%	\$20	\$75
Non-formulary Brand	50%	\$35	\$75
	You Pay	Your Minimum Payment	Your Maximum Payment
Mail Order (for prescriptions taken on an ongoing basis)			
Generic	\$10	\$10	\$10
Formulary Brand	\$60	\$60	\$60
Non-formulary Brand	\$100	\$100	\$100

Mandatory Generic Drugs

The prescription drug program associated with the PPO and EPO Plans require that you use generic drugs when they are available. If you choose a brand name drug, you will pay the difference between the generic drug and the brand name drug. This cost is in addition to the coinsurance for the formulary or non-formulary brand name drug.

Drugs Covered:

- ✓ Federal legend drugs (that is, drugs that federal law prohibits dispensing without a prescription), except those to improve or restore sexual function and except those otherwise excluded from the program
- ✓ Compound prescriptions containing at least one legend ingredient, except those otherwise excluded from the program
- ✓ Injectables, except as prohibited by applicable law
- ✓ Insulin
- ✓ Diabetic supplies
- ✓ Disposable insulin syringes and needles

- ✓ Oral contraceptives
- ✓ Smoking cessation products, but not those dispensed over-the-counter
- ✓ Retin-A and Differin (for covered individuals under age 25)
- ✓ Fertility (lifetime maximum of \$3,000)

Drugs Not Covered:

- ✓ Anorexiants for weight reduction
- ✓ Devices and appliances
- ✓ Durable medical supplies
- ✓ Growth hormones
- ✓ Immunization agents, biological sera, blood or blood plasma
- ✓ Investigational, experimental or illegal drugs
- ✓ Over-the-counter items
- ✓ Retin-A and Differin (for anyone over age 25)
- ✓ Rogaine (or similar products)
- ✓ Impotence-related drugs (such as Viagra or similar products)

Please note: This is not a complete list of the items which are not covered by the program. If you have any questions about the possible coverage of a particular item, please contact Express Scripts, the prescription drug program administrator.

Medical Case Management Program

The Managed Choice Medical Options may provide alternative medical treatment benefits in certain cases through the Case Management Program. Case Management is a managed care program that provides assistance and care to Plan participants who have severe injuries or chronic or catastrophic illnesses.

The Case Manager acts as a guide through the complex medical system to see that all the medically necessary care is arranged for you and your family. These nurse specialists are trained to be aware of the latest treatments and sources of help for you and your family to help you make the best use of medical services.

The key to the success of this program is early identification. Most of the referrals will be made at the time of hospitalization by having your physician call your insurance provider (BCBSIL or Aetna). The Case Manager will determine whether your condition involves any of the following diagnoses:

- ✓ AIDS
- ✓ ALS (Lou Gehrig's disease)
- ✓ Anorexia nervosa
- ✓ Crohn's disease

- ✓ Chronic obstructive pulmonary disease
- ✓ Severe stroke
- ✓ Multiple fractures
- ✓ Osteomyelitis
- ✓ Severe rheumatoid arthritis
- ✓ Selected blood dyscrasias
- ✓ Selected osteoarthritis
- ✓ Chemical dependency
- ✓ Severe burns
- ✓ Multiple sclerosis
- ✓ Neonatal high-risk infants
- ✓ Select mental health conditions

This program is completely voluntary and requires the agreement of participation from you, your physician and your insurance provider (BCBSIL or Aetna) Case Managers in consultation with your insurance provider (BCBSIL or Aetna) Medical Directors.

If you become a candidate, your insurance provider (BCBSIL or Aetna) consultant will review your case and propose treatment in consultation with your doctor. If the proposed plan is more cost effective than your current (or projected) treatment, and you and your doctor decide that this treatment would be best, generally the Plan will pay benefits for the alternative treatment.

Your insurance provider (BCBSIL or Aetna) has the right to discontinue your participation in this program upon notice to you and your doctor. You and your doctor also have the right to discontinue treatment upon notice to your insurance provider (BCBSIL or Aetna).

The following services or supplies may be covered as alternative medical treatment benefits:

- ✓ Home Health Care, including (but not limited to) total parenteral nutrition (TPN), antibiotic administration, cardiac rehabilitation, respiratory therapy, certain drugs and durable medical equipment
- ✓ Extended care facility services
- ✓ Rehabilitation services
- ✓ Services for outpatient alcohol and drug rehabilitation treatment
- ✓ Outpatient mental health care services

The alternative medical treatment benefits you may receive are not limited to those listed. However, any contemplated alternative treatment must be approved by your insurance provider (BCBSIL or Aetna) and the Plan Administration as a cost-effective alternative.

Retiree Medical Benefits

An active employee who terminates service because of early or normal retirement and immediately thereafter begins receiving his benefits under the Group Retirement Plan may be eligible for retiree medical benefits. An employee must start receiving his benefits under the Group Retirement Plan immediately at termination or following continuation pay in order to qualify for retiree medical benefits. Under certain circumstances, such employee's dependent(s) may also qualify for these medical benefits.

If such benefits may be available to you after you retire, you will be sent more information about them shortly before you retire.

Please note: The Managing Board of ABN AMRO Bank N.V. unconditionally reserves the absolute right to amend, modify and/or terminate retiree medical coverage and/or benefits, in whole or in part, at any time (whether before, during or after your retirement), in any manner and for any reason. The retiree medical benefits described above represent a benefit currently (that is, as of the date of this SPD) available to a participant who meets all applicable requirements for such coverage. If you are not currently eligible, please be aware that no promise or representation, express or implied, is made that this benefit will be available when you would otherwise be eligible. Further, the fact that any level of subsidy for such coverage and/or benefits is provided at any time by an Employer shall in no way obligate or require the provision of such subsidy at any other time.

All retiree medical coverage and benefits hereunder shall be coordinated with Medicare coverage and benefits in accordance with all applicable laws and regulations and the absolute discretion of the Plan Administrator, exercised in a uniform and non-discriminatory manner.

Situations That May Affect Your Coverage

How to File a Claim

Whether or not you need to file a claim depends on the option you choose.

Option I: PPO Plan

- ✓ Network – There is no claim form for you to complete.
- ✓ Out-of-network – You are responsible for obtaining and filing claim forms. Claim forms are available on My HR or by calling Ask HR.

Option II: Select Network Plans (EPO)

- ✓ Network – There is no claim form for you to complete.
- ✓ There are no out of network benefits available. If you use an out of network physician or facility, the costs incurred will be your responsibility.

Coverage During a Leave of Absence

Generally, if you are on a leave of absence on account of sickness or injury, applicable medical coverage under the Plan will continue for the time during which you are sick or injured. However, if your leave of absence is on account of military service, such coverage will typically continue for only two months.

Nevertheless, if you are absent from your position with the Company because of your service in the uniformed services, you may choose to continue your medical coverage. You may continue your coverage (and that of your covered dependents) for whichever is the shorter of the following two periods: (i) the 18-month period which begins on the date on which your absence from work because of such service begins, or (ii) the period which ends on the day after the date on which you fail to apply for or return to your position, as determined under applicable law.

Generally, the cost of such continuation coverage is 102% of the full cost of the applicable medical coverage. However, if you perform service in the uniformed services for fewer than 31 days, you will not be required to pay more than the employee share for such applicable coverage.

If you will be absent from work because of military service, you are urged to contact Corporate Benefits well in advance of such service to discuss your situation and the possible restrictions which may apply.

Generally, during a paid leave of absence, your contributions for medical coverage will continue to be made through payroll deductions. During an unpaid leave of absence, you will be required to make payments for coverage by personal check payable to LaSalle Bank Corporation. If you do not make the required contributions, your coverage will cease. You have a three-month grace period in which to make the required contribution before coverage stops.

Family Leave of Absence – According to the Family and Medical Leave Act of 1993, if you are a full-time employee, you may be eligible for up to 12 weeks of unpaid leave per year if you have a serious illness, adopt or give birth to a child, or need to care for a seriously ill spouse, child or parent. Your medical coverage may be continued during this time, with the Company paying the same portion of the cost it normally pays. You will be responsible for paying your portion of the cost of applicable coverage. To continue such coverage, you will be required to make the appropriate monthly contributions by personal check payable to LaSalle Bank Corporation.

Changing Your Coverage

As previously discussed, certain events give rise to special enrollment rights. Such special enrollment rights may allow you (and/or an otherwise eligible dependent) to enroll for medical coverage at a time when enrollment would otherwise not be allowed. See "Special Enrollment Periods" for more information.

Similarly, there are other times, in addition to the annual enrollment period, at which changes in medical coverage may be permitted.

You may change your coverage if you have a qualifying change in status. Typically, each of the following events may be considered such a change in status:

- ✓ Your marriage, divorce, legal separation or annulment
- ✓ The birth of a dependent to you, adoption of a dependent by you, or placement for adoption of a dependent with you
- ✓ The death of your spouse or dependent
- ✓ A change in job status from full time to part time (or vice versa) by you, your spouse or your dependent
- ✓ Commencement of or return from an unpaid leave of absence for you, your spouse or your dependent
- ✓ Commencement or termination of your, your spouse's or your dependent's employment
- ✓ An event that causes your dependent to satisfy or cease to satisfy the requirements of coverage due to attainment of age, student status, marital status or similar circumstance

If you have a qualifying change in status, you must contact Ask HR requesting a change in coverage within 30 days of the event. The change in status must result in you, your spouse or your dependent gaining or losing eligibility for medical coverage sponsored by the Company, or by your spouse's or your dependent's employer. Also, the change in election must correspond to that gain or loss of coverage. This means that the change in coverage must be consistent with the life event. For example, if you have a baby, adding a dependent to your coverage would be consistent; dropping your husband from coverage would not. You may be required to provide evidence of the event.

When You Have Coverage from Another Source

If you or a covered dependent is covered by more than one group medical plan (for example, your spouse's plan), the "coordination of benefits" feature of the ABN AMRO Group Medical Plan will apply to prevent duplication of payments.

The plan that is primarily responsible for a person's expenses – that is, the plan that pays benefits first – is considered the primary coverage for that person.

Generally, a group medical plan that does not have a "coordination of benefits" provision is the primary plan. However, if each plan involved has a coordination of benefits provision, the following rules apply:

For You – The ABN AMRO Group Medical Plan is your primary coverage, if you participate. A plan that covers you as someone's dependent is your secondary plan.

For Your Spouse – The plan provided by your spouse's employer is primary if your spouse is enrolled for that coverage. The ABN AMRO Group Medical Plan is primary only if your spouse does not participate in any employer-sponsored or Medicare coverage.

For Your Children – If your children are covered by more than one group medical plan, the "birthday rule" determines which plan (yours or your spouse's) is primary. The plan covering the spouse whose birthday (month and day) falls earlier in the calendar year is primary for the children. If both parents have the same birthday, the plan that has covered the parent for a longer period of time is primary.

If you and your spouse are divorced or separated, the plan that covers the parent who has custody of the child is primary for the child. If custody is not established, the plan that covers the parent with primary financial obligations for the child (as outlined by the court) is primary for the child.

The provisions of a valid and applicable Qualified Medical Child Support Order, as defined by ERISA (a "QMCSO"), will determine which coverage will apply for the child who is the subject of such QMCSO, regardless of the above discussion. Participants and beneficiaries may obtain from the Plan Administrator, without a charge, a copy of the applicable procedures with respect to QMCSOs.

Other Important Information About Coordination of Benefits – To help administer and enforce the above and any other applicable rules, the Medical Plan has the right to give and/or receive information on benefits and expenses with respect to each person who has medical coverage, without the consent of such person. Each claim submitted under the Medical Plan must contain sufficient information to permit the application of all applicable rules.

Assuming coverage under the ABN AMRO Group Medical Plan and another group medical plan (which also has a provision regarding "coordination of benefits") in the following three situations, in general here's how the ABN AMRO Medical Plan coordinates with such other plan in each of those situations:

For You	
If:	Then:
ABN AMRO Group Medical Plan coverage is greater than your spouse's plan's coverage ...	The ABN AMRO Group Medical Plan pays the ABN AMRO Group Medical Plan benefit.
ABN AMRO Group Medical Plan coverage is equal to or less than your spouse's plan's coverage ...	The ABN AMRO Group Medical Plan pays the ABN AMRO Group Medical Plan benefit.
For Your Spouse	
If:	Then:
ABN AMRO Group Medical Plan coverage is greater than your spouse's plan's coverage ...	The ABN AMRO Group Medical Plan pays the difference between benefits from the other plan and benefits from the ABN AMRO Group Medical Plan.
ABN AMRO Group Medical Plan coverage is equal to or less than your spouse's plan's	The ABN AMRO Group Medical Plan will pay no additional benefits.

coverage ...	
For Covered Children	
If:	Then:
Your birthday (month, day) occurs first in the calendar year ...	The ABN AMRO Group Medical Plan pays benefits first. After the Medical Plan pays, you can then submit bills to your spouse's plan. Reimbursement from your spouse's plan will depend on your spouse's plan's coordination of benefits rules.
Your spouse's birthday is first ...	Your spouse's plan pays benefits first; submit your children's bills to your spouse's plan first. Expenses not covered under your spouse's plan may be covered by the ABN AMRO Group Medical Plan, up to the amount the ABN AMRO Group Medical Plan would have paid alone (if it were primary).
You and your spouse have the same birthday ...	The plan covering you or your spouse for the longer period of time will pay first.
You are divorced and you have custody of your children ...	The ABN AMRO Group Medical Plan pays benefits first.
A valid QMCSO applies ...	The provisions of the valid QMCSO govern with respect to the child who is the subject of such QMCSO, regardless of the above.

When Your Medical Coverage Ends

Your coverage under the PPO or EPO Plan will end when the earliest of the following occurs:

- ✓ Your employment ends for any reason, except in certain cases of disability or retirement
- ✓ You no longer meet the Plan's eligibility requirements
- ✓ You do not make a required contribution
- ✓ The Plan (or part of the Plan) ends

Generally, coverage for an eligible family member ends on the date on which such person is no longer an eligible dependent, or on the date on which you are no longer covered under the Plan, whichever comes first.

When your coverage ends, you and your covered dependents may be entitled to purchase continued medical coverage under a federal law known as COBRA. (See the Important Plan Information section of this Handbook for more information.)

Extended Medical Benefits – If you or a covered dependent is hospitalized when applicable coverage ends, otherwise- eligible expenses for that hospitalization will generally continue to be covered until the earliest of the following occurs:

- ✓ The date on which any maximum benefit for the applicable illness or injury is reached
- ✓ The date on which such hospitalization ends
- ✓ 12 months after the date on which coverage under the Medical Plan would have ended if there had been no extension for such hospitalization

Extended Medical Benefits During Disability – If you or a covered dependent is Fully Disabled on the date on which the applicable Managed Choice Medical Option is terminated, otherwise-eligible expenses for that Full Disability will generally continue to be covered until the earliest of the following occurs:

The date on which any maximum benefit for the applicable illness or injury is reached

The date on which the affected person is no longer Fully Disabled

The date on which the affected person becomes covered by another group medical plan

12 months after the date on which coverage under the Medical Plan would have ended if there had been no extension for such Full Disability

Q. What Is "Fully Disabled"?

A. Generally, you are "Fully Disabled" for purposes of the Plan when, because of illness or injury, you cannot perform your job; your dependent is "Fully Disabled" when, because of illness or injury, such dependent cannot perform his usual activities.

Administrative Information

Overpayments

If you receive an overpayment of benefits, the Company and/or the Plan has/have the right to recover the overpaid amount. If the Company and/or the Plan pays/pay too much in benefits to another plan (such as your spouse's), Plan benefits may be reduced. This helps to ensure that you receive the correct amount of benefits under the Managed Choice Medical Plan.

If you do not promptly refund the required amount, the amount of any future Medical Plan benefits payable may be reduced by the amount of the overpayment. The Company and/or the Medical Plan may have other applicable rights, as well.

Right of Reimbursement

The **ABN AMRO Group Medical Plan** "step(s) into the shoes" of each participant or other person who has coverage under the Plan (the "Benefiting Individual" with respect to all payments made by, or on behalf of, the Plan. The Plan must be reimbursed immediately from any recovery (whether as a result of a suit, judgement, settlement, compromise, or otherwise), by or on behalf of the Benefiting Individual, from or against any third party, insurer and/or other plan that is or may be responsible for (i) the accident, injury, sickness or condition that resulted in benefits being paid under the Plan and/or (ii) the medical or other expenses incurred by the Benefiting Individual as a result of the accident, injury, sickness or condition.

Any amounts a Benefiting Individual and/or Benefiting Individual's attorney receive(s) from any third party, insurer and/or other plan must be held in trust (and/or otherwise held separately) for the benefit of the Plan and promptly repaid to the Plan.

Regardless of whether **any** payment from a third party, insurer and/or other plan is characterized as "reimbursement for medical expenses," "disability," "pain and suffering" or for some other loss, the Plan's rights **with respect to applicable reimbursement** shall be a first priority claim against any third party, insurer and/or other plan, and the Plan shall be entitled to be reimbursed for all amounts paid under the Plan before the Benefiting Individual and/or the Benefiting Individual's attorney is/are entitled to keep any amounts received from the third party, insurer and/or other plan. If any balance remains after the Plan is reimbursed, those amounts may be retained by the Benefiting Individual and/or the Benefiting Individual's attorney.

Each Benefiting Individual must cooperate fully with the Plan Administrator (and/or anyone it has designated) in connection with all activities the Plan Administrator, in the exercise of its discretion, deems necessary or advisable to safeguard the pertinent rights of the Plan. These activities include, but are not limited to : (i) completing and signing all forms and papers as the Plan Administrator deems necessary to secure the applicable rights of the Plan; (ii) informing the Plan of potential or actual claims that the Benefiting Individual and/or the Benefiting Individual's agent(s) has/have or may have against third parties, insurers and/or other plans; (iii) supplying any information required by the Plan Administrator as soon as possible, and in all cases before the Benefiting Individual agrees to

any settlement or compromise with any third party, insurer and/or other plan; and (iv) taking no action that may impair the Plan's rights with respect to reimbursement. In the exercise of its discretion, the Plan Administrator may require the completion of an activity (for example, the receipt of an applicable document signed by the Benefiting Individual or his agent) before applicable benefits under the Plan are paid to, or on behalf of, the Benefiting Individual. If the Benefiting Individual fails to cooperate fully, as determined by the Plan Administrator in the exercise of its discretion, the Plan will not have to pay future benefits to, or on behalf of, the Benefiting Individual for otherwise-eligible expenses that are incurred as a result of the accident, injury, sickness or condition at issue.

The Plan will not be responsible for any attorney's fees or costs incurred by a Benefiting Individual in connection with any claim or lawsuit against any third party, insurer, and/or other plan unless, before the time at which such fees or costs were incurred, the Plan Administrator, in the exercise of its complete discretion, agreed in writing to pay all or some portion of such fees or costs.

Other Information

See the Important Plan Information section of this Handbook for the following information:

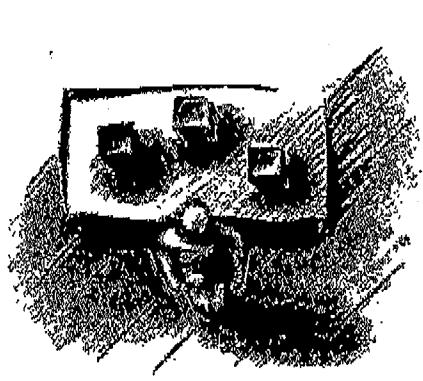
- ✓ Continuation Coverage – Medical and Dental Benefits
- ✓ Claims Procedure
- ✓ Plan Administrator and Plan Sponsor
- ✓ Agent for Service of Legal Process
- ✓ Your Rights Under ERISA

This section and the Important Plan Information section constitute a Summary Plan Description that summarizes the features of the ABN AMRO Group Medical Plan. The Summary Plan Description for the Medical Plan is based on the applicable Plan document, but it is not the Plan document. If there are any conflicts or inconsistencies between or among this Summary Plan Description, any oral representation(s) and the Plan document, the applicable Plan document will always control.

Please note: The Managing Board of ABN AMRO Bank N.V. unconditionally reserves the absolute right (1) to amend, modify and/or terminate the Medical Plan, in whole or in part, in any manner, at any time and for any reason, and (2) to discontinue, in accordance with the applicable governing document, ABN AMRO's association with any or each HMO which is offered as an alternative to participation in the Medical Plan.

Participation in the Medical Plan or in any applicable HMO is not a guarantee of employment with an Employer, nor does the Medical Plan or any HMO interfere in any way with an Employer's rights under applicable law to discipline or discharge any employee.

Important Plan Information



Important Plan Information

For information on...

See page...

An Overview of This Section

Administrative Information

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An Overview of This Section

This section of *Your Benefits Handbook* – *Summary Plan Descriptions* (the “Handbook”) contains important information about the ABN AMRO Group Plans (collectively, the “Plans” or individually, the “Plan”) described in the Handbook. You should refer to this section for information regarding the more general aspects of the Plans (for example, among other things, the administration of the Plans and your rights under federal law). Each individual Plan description should be reviewed for more specific details about a particular Plan.

This *Important Plan Information* section is a part of the Summary Plan Description for each Plan which has a separate section in this Handbook.

You may examine the documents which constitute the Plans at the office of the Plan Administrator, at the address that follows. You may obtain copies of the Plans and related documents, upon payment of reasonable per-page copying costs, upon written request to the Plan Administrator. All questions about the Plans and this Handbook should be directed to the Plan Administrator, the ABN AMRO Group U.S. Employee Benefits Committee, whose representative is the:

Senior Vice President –
Human Resources
ABN AMRO North America, Inc.
135 South LaSalle Street
Chicago, Illinois 60603
1-312-904-2160

Insured Versus Self-Insured Benefits

Some of the information in this section of the Handbook pertains to benefits provided by insurance companies (insured benefits); other information pertains to benefits provided from your Employer’s general assets (self-insured benefits).

Insured benefits are governed by applicable insurance policies, insurance certificates, riders and/or other insurance documents. These documents are the official statements on insured benefits. The summaries of insured benefits in this Handbook are based on such official statements, but they are not the official statements. In the case of any conflict or inconsistency between an applicable insurance policy, certificate or other applicable insurance document and the information in this Handbook, the insurance policy, certificate or other applicable insurance document will always control.

Self-insured benefits are governed by the applicable Plan documents. Similarly, the summaries of self-insured benefits in this

IMPORTANT PLAN INFORMATION

Handbook have been prepared from the applicable Plan documents, but such summaries are not the official Plan documents. In the case of any conflict or inconsistency between an applicable Plan document and the information in this Handbook, the applicable Plan document will always control.

Please note: Oral representations cannot modify, extend or enlarge any rights or responsibilities contained in the applicable Plan documents or the applicable insurance documents.

Administrative Information

Plan Sponsor

ABN AMRO Bank N.V.*
 135 South LaSalle Street
 Chicago, Illinois 60603
 1-312-904-2160
 Employer Identification Number:
 13-5268975

Other sponsors of the Plans (also known as "Employers") are the following:

- LaSalle National Bank;
- Any entity (known as a "Related Entity") within the following three groups which acts as a sponsor of the Plans:
 - (i) any corporation which is a member of the same controlled group of

corporations as ABN AMRO Bank N.V.,
 (ii) any trade or business which is under common control with ABN AMRO Bank N.V., and

(iii) any other corporation which has been designated as a Related Entity by the Managing Board of ABN AMRO Bank N.V.; and

- Any successor of any of the preceding entities.

"ABN AMRO," "Organization" and "Employer" (or "Employers") are used, often interchangeably, in this Handbook. Unless the context in which the term is found plainly requires a different interpretation, you may assume that, under most circumstances, such term refers to (or includes) your employer.

You may obtain from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan(s) and, if the employer is a Plan sponsor, the sponsor's address.

Plan Administrator

ABN AMRO Group U.S. Employee Benefits Committee*
 c/o Senior Vice President -
 Human Resources
 ABN AMRO North America, Inc.
 135 South LaSalle Street
 Chicago, Illinois 60603
 1-312-904-2160

The respective Plan Administrator is responsible for the day-to-day operation of the applicable Plan or Plans and has full discretion and exclusive authority to interpret, construe and administer the terms and conditions of the Plan(s), and to adopt and enforce rules for administration of the Plan(s), where such discretion and authority have not been delegated to the appropriate insurance organization as Claims Administrator or insurer of benefits.

The Plan Administrator, the Claims Administrator or the appropriate insurer, as applicable, has the authority to decide, in accordance with the terms of the applicable Plan or insurance policy, certificate or other insurance document, all issues with respect to eligibility for benefits thereunder.

Plan Trustee

LaSalle National Bank, 135 South LaSalle Street, Chicago, Illinois 60603, is the Trustee of the following Plans:

- The ABN AMRO Group Profit Sharing and Savings Plan,
- The ABN AMRO Group Retirement Plan,
- The ABN AMRO Group Welfare Plan, and
- The ABN AMRO North America, Inc. SevTrust Plan.

The Trustee holds the assets of each of these Plans in a separate trust for the benefit of that Plan's participants and beneficiaries and is responsible for the prudent investment of the assets of three of the four Plans previously mentioned. Plan participants (or their beneficiaries) direct the investment of amounts credited to their accounts under the Group Profit Sharing and Savings Plan. However, the Trustee is responsible for the selection of the investment funds available under the Group Profit Sharing and Savings Plan and for the prudent investment of those assets of such Plan whose investment is not directed by the participants (or beneficiaries) themselves.

Funding Methods

Medical Plan and Dental Plan

Medical Plan and Dental Plan benefits are provided through a trust maintained by the Trustee. Your Employer contributes to this trust to fund benefit payments under the Medical Plan and the Dental Plan.

United Healthcare Insurance Company ("United Healthcare"), P.O. Box 30555, Salt Lake City, Utah 84130-0555, is the Claims Administrator for the Medical Plan. United Healthcare does **not** insure or guarantee medical benefits; it merely provides claims administration services to the Medical Plan.

MetLife (P.O. Box 8740, Dayton, Ohio 45401-8740) is the Claims Administrator for the Dental Plan. MetLife does **not** insure or guarantee dental benefits; it merely provides claims administration services to the Dental Plan.

Health Maintenance Organization (HMO)

Instead of participating in the Medical Plan, you can choose to participate in an HMO if one is available to you. The HMOs **do** insure medical benefits. The following HMOs are currently available in the following areas:

Chicago

HMO Illinois/Blue Cross/
Blue Shield of Illinois
1515 West 22nd Street
Suite 200
Oak Brook, Illinois 60521

Humana Health Plan, Inc.
222 South Riverside Plaza
Suite 1010
Chicago, Illinois 60606

Rush Prudential HMO, Inc.
233 South Wacker Drive
Suite 3900
Chicago, Illinois 60606-6309

Michigan

Blue Care Network - Great Lakes
(an affiliate of Blue Cross and
Blue Shield of Michigan)
5540 Glenwood Hills Parkway
Southeast
Grand Rapids, Michigan 49512

Health Alliance Plan
2850 West Grand Boulevard
Detroit, Michigan 48202

M-Care
2301 Commonwealth Boulevard
Ann Arbor, Michigan 48105-2945

New York and New Jersey Area

Aetna U.S. HealthCare of
New York
333 Earle Ovington Boulevard
Suite 502
Uniondale, New York 11553

Aetna U.S. HealthCare of
New Jersey
333 Earle Ovington Boulevard
Suite 502
Uniondale, New York 11553

Oxford Health Plans
1133 Avenue of the Americas
New York, New York 10036

Vytra Healthcare Long Island, Inc.
Corporate Center
395 Service Road
Melville, New York 11747-3127

Pittsburgh

Aetna U.S. HealthCare of
Pittsburgh
333 Earle Ovington Boulevard
Suite 502
Uniondale, New York 11553

California

PaciFiCare of California
One Market Plaza
Spear Street Tower, 12th Floor
San Francisco, California
94105-1000

Dental Maintenance Organization

Instead of participating in the Dental Plan, you can choose to participate in a dental maintenance organization if one is available to you. The dental maintenance organization **does** insure dental benefits. The following dental maintenance organizations are currently available in the following areas:

Florida, Illinois, Indiana, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, Ohio, Rhode Island, Utah and Virginia

Prudential HealthCare Preferred Provider
Dental Maintenance Organization (DMO®)**

*And also for residents of Massachusetts only: Prudential HealthCare Preferred Provider Dental Maintenance Organization (DMO®)** - Massachusetts*

The Prudential Insurance
Company of America
Southwestern Group Operations
One Prudential Circle
Sugar Land, Texas 77478

*Alabama, Arizona, Colorado,
Connecticut, Delaware, District of
Columbia, Georgia, Hawaii, Idaho, Iowa,
Kansas, Kentucky, Maryland, Mississippi,
Missouri, New York, Oklahoma, Oregon,
South Carolina, South Dakota, Tennessee,
Vermont, Washington, West Virginia and
Wisconsin*

Prudential HealthCare Dental
Maintenance Organization (DMO®)**

The Prudential Insurance
Company of America
Southwestern Group Operations
One Prudential Circle
Sugar Land, Texas 77478

*Arkansas, New Mexico and North
Carolina*

Prudential HealthCare Managed Dental
Organization (MDO®)

The Prudential Insurance
Company of America
Southwestern Group Operations
One Prudential Circle
Sugar Land, Texas 77478

California

Prudential HealthCare Dental
Maintenance Organization (DMO®)** -
California

Prudential Health Care Plan
of California, Inc.
The Prudential Dental
Maintenance Organization
P.O. Box 9156
Van Nuys, California 91409

New Jersey

Prudential HealthCare Dental
Maintenance Organization (DMO®) -
New Jersey

The Prudential Insurance
Company of America
Southwestern Group Operations
One Prudential Circle
Sugar Land, Texas 77478

Pennsylvania

Prudential HealthCare Dental
Maintenance Organization (DMO®)** -
Pennsylvania

The Prudential Insurance
Company of America
Southwestern Group Operations
One Prudential Circle
Sugar Land, Texas 77478

Texas

DMO®** - The Prudential Dental
Maintenance Organization

Prudential Dental Maintenance
Organization, Inc.
Southwestern Group Operations
One Prudential Circle
Sugar Land, Texas 77478

Life Insurance Plan

Benefits under the Life Insurance Plan
are provided under a separate group
insurance policy issued by Provident Life
and Accident Insurance Company:

One Fountain Square
Chattanooga, Tennessee 37402

Long Term Disability (LTD) Plan

Benefits under the LTD Plan are provided
under a separate group insurance policy
issued by UNUM Life Insurance
Company of America:

2211 Congress Street
Portland, Maine 04122

**Accidental Death and
Dismemberment (AD&D) Plan**

Benefits under the AD&D Plan are
provided under a separate group
insurance policy issued by Life Insurance
Company of North America:

1600 Arch Street
Philadelphia, Pennsylvania 19101

Travel Accident Plan

Benefits under the Business Travel Accident Plan are provided under a separate group insurance policy issued by Continental Casualty Company:

CNA Plaza
Chicago, Illinois 60685

The applicable insurance company establishes the premiums for the applicable insured plan, decides claims for benefits under such plan and pays out benefits under such plan.

Cafeteria Plan (including Health Care Reimbursement and Child Care and Dependent Care Reimbursement Accounts)

The Cafeteria Plan affords you the ability to pay for, through payroll deductions: (1) the premiums for your medical and dental coverage on a before-tax basis; (2) otherwise-not-covered medical and dental expenses on a before-tax basis from a reimbursement account; and (3) child and dependent care on a before-tax basis from a reimbursement account.

Retirement Plan

The Employers contribute an actuarially-determined amount to the Retirement Plan trust to fund the retirement benefits of participants under the Retirement Plan. The Trustee is responsible for the invest-

ment of such contributions. Participants are neither required nor permitted to make contributions to the Retirement Plan.

Profit Sharing and Savings Plan

Your before-tax (or salary deferral) contributions, along with any matching and profit sharing contributions made by your Employer, are invested as you direct among the various funds available under the Profit Sharing and Savings Plan.

SevTrust Plan

Benefits under the ABN AMRO North America, Inc. SevTrust Plan (the "SevTrust Plan") are provided through a trust maintained by the Trustee. The Employers contribute to this trust to fund payments under the SevTrust Plan.

Legal Process

The Plan Administrator is designated as the agent for service of legal process. Service of legal process may also be made on the Trustee.

Plan Year

The records for each of the Plans are maintained on a Plan Year basis. The Plan Year is the calendar year (that is, the 12-month period from January 1 through December 31).

Plan Summary

Plan Name	Type of Plan	Plan Number	Plan Administrator, Claims Administrator or Insurer
ABN AMRO Group Welfare Plan (Medical)	Welfare - Medical	502	The Committee* (Plan Administrator) United Healthcare Insurance Co. (Claims Administrator)
ABN AMRO Group Welfare Plan (Dental)	Welfare - Dental	502	The Committee* (Plan Administrator) MetLife (Claims Administrator)
ABN AMRO Group Welfare Plan (Life)	Welfare - Life	502	Provident Life and Accident Insurance Co. (Insurer)
ABN AMRO Group Welfare Plan (LTD)	Welfare - LTD	502	UNUM Life Insurance Co. of America (Insurer)
ABN AMRO Group Welfare Plan (AD&D Plan)	Welfare - AD&D	502	Life Insurance Co. of North America (Insurer)
ABN AMRO Group Travel Accident Plan	Welfare - Business Travel Accident	505	Continental Casualty Company (Insurer)
ABN AMRO Group HMO Medical Plan	Welfare - Medical and Dental	506	The Committee* (Plan Administrator) Various HMOs (Insurers) Various Dental Maintenance Organizations (Insurers)
ABN AMRO Group Cafeteria Plan (ABN AMRO Health Care Reimbursement Plan)	Medical/Dental Reimbursement	507	The Committee* (Plan Administrator) United Healthcare Insurance Co. (Claims Administrator)
ABN AMRO Group Cafeteria Plan (ABN AMRO Child Care and Dependent Care Reimbursement Plan)	Dependent Care Reimbursement	507	The Committee* (Plan Administrator) United Healthcare Insurance Co. (Claims Administrator)
ABN AMRO Group Retirement Plan	Pension - Defined Benefit	002	The Committee* (Plan Administrator)
ABN AMRO Group Profit Sharing and Savings Plan	Pension - Defined Contribution	003	The Committee* (Plan Administrator)
ABN AMRO North America, Inc. SevTrust Plan	Welfare - Severance	600	ABN AMRO North America, Inc. (Plan Administrator)

*The Committee is the ABN AMRO Group U.S. Employee Benefits Committee, whose representative is the Senior Vice President - Human Resources, ABN AMRO North America, Inc.

Future of the Plans

Although the Plans are currently expected to continue indefinitely, the Managing Board of ABN AMRO Bank N.V. unconditionally reserves the absolute right to amend, modify or terminate any or all of the Plans, at any time and for any reason.

No Guarantee of Employment

Participation in the Plans is not a guarantee of employment with an Employer, nor do these Plans interfere in any way with an Employer's rights under applicable law to discipline or discharge any employee.

Pronouns Used in This Handbook

The masculine pronouns are used in this Handbook to refer to various individuals. Unless the context clearly requires otherwise, you should assume that such pronouns refer to either males or females or to both males and females, as applicable.

Continuation of Coverage – Medical and Dental Benefits

About COBRA

If you have medical and/or dental coverage, COBRA may give you the right to continue such coverage, **for a limited time at your expense**, if you experience an event which would otherwise cause you to lose coverage. If your spouse and/or your dependent(s) had such health coverage through your Employer, they may, likewise, be able to continue this coverage. COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985, the law that added the health care continuation coverage requirements. Such continuation coverage is called "COBRA coverage."

Please note: Generally, COBRA coverage will not be provided unless you (and/or your spouse and/or your dependent(s)) properly elect COBRA coverage and timely pay for it. Also, since COBRA coverage is a continuation of whatever medical and/or dental coverage applied at the time of the applicable "qualifying event," it is subject to any applicable Plan or

IMPORTANT PLAN INFORMATION

HMO and/or dental maintenance organization changes.

Qualifying Events for COBRA Coverage

Termination of Employee's Employment

If you have medical and/or dental coverage and you terminate employment with an Employer for any reason other than gross misconduct, COBRA will generally give you, your covered spouse and/or your covered dependent(s) the right to continue such coverage for up to 18 months after the date of the termination of your employment.

The 18-month period can be increased to 29 months for each member of your family who is otherwise entitled to COBRA coverage if you, your covered spouse or a covered dependent is determined, under the Social Security Act, to have been totally and permanently disabled at any time during the first 60 days of COBRA coverage. To be entitled to this additional 11 months of COBRA coverage, the affected person (whether you, your spouse or your dependent) must send a copy of the Social Security Administration's determination of total and permanent disability to Corporate Benefits **no later than 60 days** after the date of such determination and **before**

the end of the initial 18-month period of COBRA coverage. The person who obtains this extended COBRA coverage is also required to notify Corporate Benefits no later than 30 days after any final determination, under the Social Security Act, that such person is no longer disabled.

Reduction in Employee's Working Hours

If you have medical and/or dental coverage and your working hours are reduced to a level at which the coverage would otherwise stop, COBRA will generally give you, your covered spouse and/or your covered dependent(s) the right to continue such coverage for up to 18 months after the date on which your working hours are reduced.

The 18-month period can be increased to 29 months for each member of your family who is otherwise entitled to COBRA coverage if you, your covered spouse or a covered dependent is determined, under the Social Security Act, to have been totally and permanently disabled at any time during the first 60 days of COBRA coverage. To be entitled to this additional 11 months of COBRA coverage, the affected person (whether you, your spouse or your dependent) must send a copy of the Social Security Administration's determination of total and permanent disability to Corporate

Benefits **no later than 60 days** after the date of such determination and **before the end** of the initial 18-month period of COBRA coverage. The person who obtains this extended COBRA coverage is also required to notify Corporate Benefits no later than 30 days after any final determination, under the Social Security Act, that such person is no longer disabled.

Death, Divorce or Legal Separation of Employee

If you die, divorce or legally separate from your spouse while you have medical and/or dental coverage and this event would otherwise discontinue the applicable coverage for your spouse and/or your dependent(s), these persons may generally continue such coverage for up to 36 months after the date of your death, divorce or legal separation.

Change of Dependent Status

If you have medical and/or dental coverage, and your covered dependent reaches an age or condition which would otherwise result in the loss of applicable coverage, such person may generally continue such coverage for up to 36 months after the date on which he attained that age or condition.

Employee Becomes Entitled to Medicare

If you have medical and/or dental coverage and you become entitled to (that is, covered by) Medicare, the result of which would otherwise be the loss of applicable coverage for your spouse and/or your dependent(s), these individuals may generally continue such coverage for up to 36 months after you become entitled to Medicare.

Second "Qualifying Event"

Generally, if your covered spouse or covered dependent experiences an event that would allow the election of COBRA coverage at a time when such person already has COBRA coverage because of your termination of employment or reduction in working hours, COBRA coverage may be extended for up to 36 months (but no longer) from the date of the first qualifying event.

If you terminate employment or your working hours are reduced **on a date which occurs fewer than 18 months after the date on which you became entitled to Medicare**, COBRA coverage for your spouse and/or your dependent(s), if they are otherwise eligible, may be extended for up to 36 months (but no longer) after the date on which you became entitled to Medicare.



Electing COBRA

Generally, you will be sent more information about COBRA if your employment terminates or your working hours are reduced and you would otherwise lose whatever medical and/or dental coverage you had. However, the Plan Administrator typically will not know if you divorce or legally separate, or if your formerly-eligible dependent becomes ineligible as a dependent, unless you so inform Corporate Benefits.

Accordingly, you (or the affected family member) must notify Corporate Benefits, in writing within 60 days of the event of divorce, legal separation or loss of dependency status which would otherwise result in a loss of coverage, to preserve the right to elect COBRA coverage. If this written notification is not timely given, the right to elect COBRA coverage may be lost.

COBRA-at-a-Glance

COBRA coverage may continue for a total of 18 months for you or your dependents if you became eligible for COBRA because of:

- Termination of employment (except for gross misconduct)
- Reduction in your hours worked

COBRA coverage may continue for a total of 29 months for you and your dependents if at any time during the first 60 days of COBRA coverage:

- You or a covered dependent is permanently disabled according to Social Security (you pay 102% of the cost of coverage for 18 months, then 150% of the cost for the remaining 11 months)

COBRA coverage for dependents may continue for a total of 36 months if one of the following occurs:

- The covered employee dies
- The covered employee divorces or legally separates
- A dependent loses dependent status under the Plan
- The covered employee becomes entitled to Medicare

If one of the 36-month events listed above occurs while a dependent is covered under COBRA (because of an 18-month event), COBRA coverage may be extended for up to 36 months from the date of the first event. To be eligible for this extension, you or your dependent must notify Corporate Benefits within 60 days of the second event.

After Corporate Benefits has received this notification, forms for the election of COBRA coverage (COBRA Election Forms) will be forwarded to the appropriate person(s).

If you and/or an eligible family member wants COBRA coverage, the COBRA Election Forms must be returned, to the person and the address indicated on the COBRA Election Forms, **no later than 60 days after:**

- the date on which the applicable coverage would be lost on account of the qualifying event, or
- the date on which the COBRA Election Forms are sent,

whichever is later.

Cost of COBRA Coverage

If you elect COBRA coverage, you are required to pay for, at a minimum, the entire cost of coverage plus a 2% additional charge for administration. If you qualify for the extended period of coverage because of total and permanent disability, you will need to pay, for each month after the initial 18 months, 150% of the applicable premium for such coverage.

When COBRA Coverage Ends

The 18-, 29- and 36-month periods described above with respect to the duration of COBRA coverage are **maximum** periods. That is, no COBRA coverage may extend for a period longer than the applicable maximum period. However, your and/or your dependent's COBRA coverage may terminate at a point **earlier** than at the conclusion of an applicable maximum period, but not earlier than the earliest of the following:

- The date on which coverage ceases by reason of a failure to timely pay any required premium with respect to the person who had COBRA coverage;
- The date on which the Employer ceases to provide any group health plan;
- The date on which the person who had COBRA coverage becomes covered by another group health plan that does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such person;
- The date on which the person who had COBRA coverage becomes entitled to benefits under Medicare;
- In the case of a person who had extended COBRA coverage because of a disability, the month that begins more than 30 days after the date of the final determination, under the Social Security Act, that such person is no longer disabled.

COBRA coverage may also be terminated early for the same reasons for which health care coverage may be terminated early for similarly-situated active employees of the Employer who have not experienced a qualifying event.

What Happens at the End of the COBRA Continuation Period

As explained above, COBRA coverage can be provided for only a limited period of time. Generally, when the maximum allowable period of coverage ends for a person, no further coverage can be provided to that person. The Employer's health plans do not provide for the conversion of COBRA coverage into coverage under another health plan. Thus, the person for whom COBRA coverage is ending typically must make his own arrangements if he wants to further continue health care coverage.

There are two potential exceptions to the general rule explained above. The state in which you live may require that you be given a conversion option (that is, the opportunity to enroll in other health care coverage) upon the exhaustion of COBRA coverage. Also, if you have COBRA coverage because you were, immediately prior to your experiencing a qualifying event, covered under an HMO and/or dental maintenance organization, such

HMO and/or dental maintenance organization may provide a conversion option. Please contact your state's Insurance Commissioner (or Department or Division of Insurance) to determine if your state requires such a conversion option. You may also contact Corporate Benefits if you have further questions about this matter.

Claims Procedure

The Plan Administrator, the Claims Administrator or the applicable insurance company (in the case of an insured benefit) determines all rights of participants and beneficiaries to benefits under the respective Plans.

Your request for Plan benefits (also considered a claim for Plan benefits) will be given full consideration. Unless special circumstances require an extension of time, within 90 days after receipt of the claim, the Plan Administrator will notify you (or your beneficiary) of its decision with regard to the claim (the "Notice"). If special circumstances require an extension of time, you will be so informed within the initial 90-day period. However, no extension will exceed 90 days.

The Notice will set forth, if the claim is wholly or partially denied:

- The specific reason(s) for the denial, with reference(s) to the specific Plan provision(s) on which the denial is based;
- A description of any additional information or materials necessary to perfect your claim and an explanation of why the materials are needed; and
- Any appropriate information regarding the necessary steps to submit your claim for review.

To submit a request for appeal, you must file your claim for review, in writing, with the Plan Administrator within 60 days after you receive written notification of the denial, or within 60 days after the deemed denial of your claim. You (or your representative) will have reasonable access and opportunity to review pertinent documents and submit issues and comments in writing.

If an appeal of a denied claim is made, a decision will be made within 60 days after the receipt of the appeal, unless special circumstances require an extension of time. If such an extension is required, you will be informed in writing within the initial 60-day period. This

extension, if necessary, will not exceed 60 days. The notification of the decision on the appeal will be in writing and will include the specific reason(s) for the decision and specific reference(s) to the pertinent Plan provision(s) on which the decision is based.

The procedures discussed above are generally applicable to claims for benefits under the Group Retirement Plan, the Group Profit Sharing and Savings Plan and the SevTrust Plan. Procedures in addition to, or instead of, those discussed above may apply with respect to claims for Plan benefits administered or provided by an insurance company, insurance service or other similar organization that is regulated under applicable state insurance laws. Claims for benefits under the Plans offering welfare benefits (such as the Medical Plan or the Dental Plan) or under an HMO (or dental maintenance organization) are normally directed to that entity which provides claims administration services or the insured benefits.

Of course, you can always contact Corporate Benefits if you have any questions with respect to whom or where you should direct your claim.



Your Rights Under ERISA

As a participant in the Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for such copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain, once a year, a statement of the amounts credited to your account under the Group Profit Sharing and Savings Plan. The statement will be provided free of charge.
- Obtain a statement telling you whether you have a right to receive a pension from the Group Retirement Plan at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working now. If you do not have a right to a pension under the Group Retirement Plan, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once a year. The Group Retirement Plan must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plans. The people who operate your Plans, called "fiduciaries" of the respective Plans, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one may fire you, or otherwise discriminate against you in any way, to prevent you from obtaining a benefit under any of the Plans or exercising your rights under ERISA.

If your claim for a benefit under an applicable Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you a daily monetary amount until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim was frivolous.

If you have any questions about any of the Plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor:

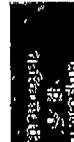
200 Constitution Avenue N.W.
Washington, D.C. 20210

Other Important Information

The PBGC Guarantee

Benefits under the Group Retirement Plan are insured by the Pension Benefit Guaranty Corporation (PBGC) if such Plan terminates.

Please note: The PBGC guarantees certain benefits under the Group Retirement Plan **only; no guarantee applies to benefits under any other Plan discussed in this Handbook.** Generally, the PBGC guarantees most vested normal age retirement benefits, early retirement benefits, and



certain disability and survivor's pensions. However, the PBGC does not guarantee all types of benefits under covered plans, and the amount of benefit protection is subject to certain limitations.

The PBGC guarantees vested benefits at the level in effect on the date of plan termination. However, if a plan has been in effect fewer than five years before it terminates, or if benefits have been increased within the five years before plan termination, the whole amount of the plan's vested benefits or the benefit increase may not be guaranteed. In addition, there is a ceiling on the amount of monthly benefit that the PBGC guarantees, which is adjusted periodically.

For more information on the PBGC insurance protection and its limitations, ask your Plan Administrator or the PBGC. Inquiries to the PBGC should be addressed to the:

Office of Communications
PBGC
2020 K Street N.W.
Washington, D.C. 20006

The PBGC Office of Communications may also be reached by calling 1-202-254-4817.

Length of Hospital Stay for Childbirth

Group health plans (such as the Medical Plan) and health insurance issuers (including HMOs) offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to fewer than 48 hours following a normal vaginal delivery, or fewer than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Exhibit 8



3. Health and wellness

Making sure we and our families are well protected in case of illness or injury is a major responsibility — and sometimes a daunting one — for each of us. Bank of America medical, dental and vision care programs not only offer a variety of plans, they are also designed to be easy to understand and use.

Bank of America pays a majority of the costs for most health care benefits. This chapter can help you make the most of your share of the costs by becoming an informed consumer of medical services. The material provided here can really help take some of the mystery out of the world of HMOs, EPOs, PPOs and other medical-related acronyms.

Well-being, however, entails more than just health care. Financial security for a family also requires different types of disability and life insurance. This chapter explains the kinds of insurance available and offers the information you need to choose the plan that best fits your needs.

Be sure to read about the company's reimbursement accounts. They can reduce your tax liability by letting you pay for some health care and dependent care expenses with before-tax dollars.

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Health and wellness

Health care benefits

Health care benefits

Overview

Bank of America offers you a comprehensive benefits package to help protect you and your family from the expenses of preventive health care, as well as the high costs of an unexpected illness, injury or accident, or in the event of death. You may choose from a variety of medical, dental and vision plans to fit your needs.

Health care plans offered by Bank of America and available in your area are summarized in the enrollment materials you receive as a newly eligible associate or during annual enrollment. Summaries are also available online at personnelonline.bankofamerica.com. (Legacy Bank of America associates may also use resources.hewitt.com/bankofamerica. Legacy Fleet associates may also use www.netbenefits.com.)

You may obtain listings of participating health care providers by contacting your health care plan. Providers may change their affiliations with health plans and this information is updated throughout the year. In order to create the appropriate provider list for you and your family, you need to determine how far you are willing to travel from your home to visit a provider or facility. You

may be willing to travel further to see a specialist than a primary care physician, and will need a separate listing for participating specialists. Once you indicate your travel distance through the Your Benefits Resource Web site (available to legacy Bank of America associates only) or by calling the Personnel Center, an appropriate provider listing will be sent to you without charge.

This handbook contains detailed information about the benefits provided by the medical plans that are listed in **Figure 3.0** later in this section.

If you enroll in a regional medical HMO/EPO that is not in **Figure 3.0**, you should receive detailed information about plan benefits directly from those plans. You may also obtain information by contacting those plans directly at the telephone numbers listed in your enrollment materials and at the end of the "Medical coverage" section later in this chapter.

Choosing your coverage — important information for specific circumstances

If your spouse or domestic partner also works for the company:

- Each of you may enroll individually as associates, in the same plan or in different plans. You may not enroll each other as a dependent. Children can be enrolled by only one of you.
or
- One of you may enroll in a plan as the associate and enroll the other as a spouse or domestic partner and eligible children as dependents in that same plan. If you elect this option and lose coverage, your spouse or domestic partner will be allowed to elect coverage as an associate and enroll you and enrolled eligible children as dependents.

If your dependent child also works for the company:

- Dependent children who are full-time or part-time associates may either enroll as associates or may be enrolled in your plan as dependents if they meet the eligibility criteria.

If you are age 65 or older:

- Active associates and their spouses or domestic partners age 65 and older do not have to be enrolled in Medicare Parts A and B to enroll in a company-sponsored medical plan. Other adult dependents age 65 or older are not eligible for enrollment in a company-sponsored medical plan.
- For retirees age 65 and older, and the spouse or domestic partner age 65 or older of any retiree, the Bank of America medical plan assumes that individual is enrolled in both Parts A and B of Medicare. Medicare will pay benefits first, and the company-sponsored medical plan will be the secondary payer.

If you are disabled and qualify for Medicare:

If you are disabled (and not actively working) and eligible for Medicare coverage because of your disability, the Bank of America medical plan assumes that you are enrolled in Parts A and B of Medicare. Medicare will pay benefits first, and the company-sponsored medical plan will be the secondary payer.

Plan identification (ID) cards

The medical HMO/EPO plans, the medical PPO plans, the medical non-network (indemnity) plans and the dental plans send plan ID cards upon your enrollment.

If you enroll in a medical plan that provides its prescription drug coverage through Caremark, you will also receive a plan ID card from Caremark. You will not receive a plan ID card for the vision plans.



Regardless of whether you have received your plan ID card, you and your dependents, if properly enrolled, are eligible to receive services from your health care plan starting with the effective date of coverage.

When health care coverage ends

Effective April 1, 2005, if your employment ends for reasons other than retirement, coverage generally ends on the last day of the pay period in which your last day of employment occurs, provided you have paid for coverage for that period.

If you retire, your associate coverage ends at the end of the month in which your last day of employment occurs. However, in 2005, associate coverage for legacy Fleet associates who are retiring ends at the end of the pay period in which the last day of employment occurs.

In other situations, coverage generally ends on the last day of the month in which one of the events listed below occurs, provided that you have paid for coverage for that month. If the event occurs on the first day of the month, coverage ends the last day of the previous month. If you receive benefits from a plan after the date coverage ends, you are responsible for reimbursing the plan for benefits provided during that period. You may be eligible for continuation or conversion coverage as described in the "Other important policies" section that follows. Coverage ends if:

- You change from a full- or part-time position to an hourly position.
- You cancel your coverage (restrictions apply).
- Bank of America no longer provides company-sponsored health care coverage.
- You're on a non-medical paid or unpaid leave of absence for more than 26 weeks.

- You're on a paid or unpaid medical leave of absence for more than 24 months.

Your coverage will also end if you do not pay the associate portion of your health care premiums for 30 days. If this occurs, your coverage will be canceled retroactively as of the end of the last period for which you had paid for coverage. Health plans may collect for any claims paid after this time.

Finally, keep in mind that certain life events can affect your eligibility for benefits and the level of benefits you receive. Examples include changing from a full-time or part-time position to an hourly position, taking a leave of absence, retiring, receiving severance under the corporate severance program, and acquiring or losing a dependent. If you experience any life event that affects your work or family status, contact the Personnel Center to determine the impact to your benefits.

Other important policies

Newborns' and Mothers' Health Protection Act

By federal law, group health plans and health insurers generally must provide minimum coverage levels to a mother and newborn child for a hospital stay in connection with childbirth. The minimum covered length of stay must be at least 48 hours following a vaginal delivery and 96 hours following a cesarean section. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn in fewer than 48 (or 96) hours. Moreover, plans and issuers may not, by federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay shorter than 48 or 96 hours.

Women's Health and Cancer Rights Act

The Bank of America health plans provide benefits related to breast reconstruction in compliance with the requirements of The Women's Health and Cancer Rights Act of 1998.

Under this federal law, group health plans and health insurance issuers that provide medical and surgical benefits for mastectomy must provide certain additional benefits related to breast reconstruction.

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the Bank of America health plans will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

Covered services will be provided in a manner determined in consultation between the attending physician and the patient. Benefits will be provided as for any other surgical expense, including with regard to any deductibles and coinsurance requirements.

Health and wellness

Health care benefits

Medical child support order

If you are ordered by a court to provide health care coverage for your child who is currently not covered by you as a dependent and you are enrolled in a plan, you can add him or her as your dependent outside annual enrollment by contacting the Personnel Center. You may also change to a plan that would provide benefits to your child if he or she lives outside the service area of the plan in which you are currently enrolled.

If the court order is a qualified medical child support order (QMCSO) and you do not comply with it, the company may be obligated to enroll your child as your dependent. The added cost of your dependent's coverage will be deducted from your pay. You can obtain a free copy of the plans' QMCSO procedures by contacting the Personnel Center.

Continuation and conversion coverage

After coverage for you and/or your enrolled dependents normally would end, the following types of continued coverage may be available:

- COBRA group continuation coverage
- Individual conversion coverage under a limited number of HMOs/EPOs (may be a different type of coverage).

Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA) continuation coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows associates and their enrolled spouses and dependent children to continue health care coverage in a company-sponsored plan after their coverage normally would end. These continuation coverage provisions also apply to children born to, or placed for adoption with, an associate during COBRA continuation coverage. COBRA continuation coverage is available for all company-sponsored health plans, including HMOs/EPOs/PPOs, dental

plans, vision plans and the Health Care Reimbursement Account.

Continued health care coverage is offered to eligible associates and their eligible dependents who otherwise would lose coverage in a company-sponsored health plan because of death, termination of employment, conversion from full- or part-time to hourly status, divorce, legal separation or a child's loss of dependent status. At Bank of America, eligible domestic partners and other adult dependents may be eligible for continuation coverage that is similar to COBRA continuation coverage.

You may elect continuation coverage for yourself and/or your eligible dependents if your coverage stops for one of the following reasons:

- Your employment ends at Bank of America for reasons other than gross misconduct.
- You lose your coverage because of a reduction in hours.

Your spouse, domestic partner or other adult dependent may elect continuation coverage if coverage stops for one of the following reasons:

- You and your spouse divorce or legally separate, or your domestic partner ceases to qualify as a domestic partner.
- Your other adult dependent under age 65 ceases to qualify as an other adult dependent.
- Your employment ends for reasons other than gross misconduct.
- You lose your coverage because of a reduction in hours.
- You die.

Your dependent child, including a child born to or placed for adoption with you during COBRA continuation coverage, is also eligible for continuation coverage, if coverage stops for one of the following reasons:

- You and your spouse divorce or legally separate, or your domestic partner ceases to qualify as a domestic partner.
- Your employment ends, for reasons other than gross misconduct.
- You lose your coverage because of a reduction in hours.
- Your dependent ceases to be a dependent child under the terms and conditions of the health care plan.
- You die.

Notification requirements for eligibility

- If you and your spouse divorce or legally separate, if your domestic partner ceases to qualify as a domestic partner, if your other adult dependent under age 65 ceases to qualify as an other adult dependent, or if a child loses dependent status, you or a family member must notify the Personnel Center within 60 calendar days after the date of the event that results in the loss of coverage, or within 60 calendar days after the date on which coverage would be lost due to the event, whichever is later.
- In the event of your death, termination of employment or reduction in hours that results in loss of coverage, Bank of America will notify the COBRA administrator.

When notified of one of the qualifying events listed above, the COBRA administrator will notify you and your family members, as appropriate, of the right to choose continuation coverage. The COBRA administrator will forward to your home a notice explaining the available options, the cost of continuing coverage, how it is paid and the time in which coverage must be elected, as well as an election form.

If continuation coverage is not elected by the due date on the notification package, you or your enrolled dependent's group coverage will end on the date that coverage would have otherwise ended.

Length of election period

COBRA coverage must be elected no later than 60 days from the date on the Notice of Right to Elect COBRA Continuation Coverage or the loss of coverage date, whichever is later.

Terms of continuation coverage

- If you or an eligible family member chooses continuation coverage, Bank of America provides coverage that is identical to the coverage being provided to similarly situated associates.
- If a family member has elected continuation coverage individually, that person also has the same coverage options as stated above.
- If your employment ends after an annual enrollment period but before year end, any elections you made to change your current coverage during annual enrollment will be canceled. You will be mailed a special enrollment package for COBRA coverage that allows you to elect continuation of your current coverage through COBRA and to change your current enrollment in a health care plan for the next plan year. In this situation, if you are not enrolled when your employment ends, you will not be able to elect continuation coverage.

Cost

- If you or an enrolled dependent elects continuation coverage, the entire monthly cost, plus an administrative fee, must be paid for each month of coverage, including the time between when you make an election and when the group coverage would have ended.

- You have 45 days from the date of your election to pay past-due premiums. All past-due and current contributions must be paid for coverage to become effective.

Duration

- If your coverage is lost because your employment ends or you have a reduction in hours, you and/or your enrolled dependents can elect coverage for 18 months from the date of the event. If a second event, as described in the next bullet, occurs in this 18-month period, and this event would have caused your spouse, domestic partner or dependent child to lose coverage had the first qualifying event not occurred, then your enrolled dependents can elect coverage for an additional 18 months, up to a maximum of 36 months. The COBRA administrator must be notified within 60 days from the date of the second qualifying event.
- If dependent coverage is lost because you die, because you and your spouse divorce or legally separate, because your domestic partner ceases to qualify as a domestic partner, because you become entitled to Medicare or because a dependent child is no longer eligible, the spouse, domestic partner or dependent child can elect coverage for a maximum of 36 months after the date of the event that resulted in loss of coverage.

Extension of continuation coverage period to 29 months in case of disability

All qualified beneficiaries are eligible for a maximum of 29 months (rather than 18 months) of continuation coverage if you or an enrolled spouse, domestic partner or dependent child is disabled as determined under the Social Security Act:

- At the time your employment ends or your hours are reduced, or within the first 60 days of continuation coverage **and**
- Coverage stops because of your termination of employment or your reduction in hours.

This special coverage will stop on the first day of the month that begins at least 31 days after the date the individual is determined to no longer be disabled. To receive the extended coverage, the disabled individual must provide notice of the Social Security Administration's determination of disability to the COBRA administrator within 60 days of the determination and before the end of the regular 18-month period. If the determination was made before the qualifying event, notice of the determination must be provided within the first 60 days of continuation coverage.

Additionally, the cost of coverage for months 19 through 29 will be 150% of the applicable health care plan premium. This extended coverage is not available if the disabled individual is enrolled as an "other adult dependent."

End of continuation coverage

Continuation coverage ends in any of the following circumstances:

- The contribution for the continuation coverage is not paid within 30 days of the due date.
- The person electing continuation coverage subsequently becomes covered through another group health plan, and the plan does not exclude that person's pre-existing condition.
- The person electing continuation coverage subsequently becomes entitled to Medicare coverage.
- Bank of America no longer provides group health coverage to any of its associates or retirees.

Health and wellness

Health care benefits

Notice of end of continuation coverage

Shortly before continuation coverage ends, you will be sent a notice reminding you when continuation coverage will stop. In general, when continuation coverage ends, no individual conversion coverage is available. (Some regional HMOs/EPOs may have a conversion option or other coverage if required by state law.)

Other adult dependents

- Other adult dependents can receive continuation coverage in the circumstances described above, except that continuation coverage generally may not extend beyond 18 months from the date of the event that causes the other adult dependent's coverage to end.
- However, in the event of the associate's death, continuation coverage can continue for 36 months.
- In no event will regular or continuation coverage for an other adult dependent extend beyond the date the individual turns 65.

Creditable coverage from

Bank of America

- When your group health coverage or COBRA continuation coverage ends, you will be mailed a certificate called a Health Insurance Portability and Accountability Act (HIPAA) statement that shows the length of time you have been continuously enrolled in coverage under the Bank of America Group Benefits Program. This period is called your creditable coverage.
- Your creditable coverage may become important if you enroll in another health care plan that will not cover a pre-existing medical condition until you have been enrolled in that plan for a certain period of time. That plan must generally count your creditable coverage toward satisfying its pre-existing condition exclusion period, as long as you have not had a break in

coverage of at least 63 days (not counting any required waiting period to be covered under that plan).

Converting to an individual policy

- When regular group coverage or COBRA continuation coverage ends for you or your enrolled dependents, some regional HMO/EPO plans may permit conversion to an individual policy. Most HMO/EPO plans and the PPO plans, non-network (indemnity) plans, and dental and vision plans do not have conversion options.
- It is your responsibility to contact the plan directly within 31 days from the date the group coverage ends if you have the option and wish to convert.
- You must pay the entire charge for an individual conversion policy.
- You should review your disclosure materials or contact the HMO/EPO directly for the special provisions on conversion to an individual policy.

Bank of America health plans notice of privacy practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and disclosure of protected health information

As a participant in a Bank of America group health care plan, you are entitled to have the privacy of your individual health information protected by the plan. In addition, federal law requires that this notice be given to you regarding policies and procedures of the plan concerning your protected health information.

The plan is permitted to make certain types of uses and disclosures of your protected health information, without your authorization, for treatment, payment and health care operations purposes.

For treatment purposes, such use and disclosure may take place in providing, coordinating, or managing health care and its related services by one or more of your providers, such as when your primary care physician consults with a specialist regarding your condition.

For payment purposes, such use and disclosure may take place to determine responsibility for coverage and benefits, such as when health plans confer to resolve a coordination of benefits issue. The plan also may use your protected health information for other payment-related purposes, such as to assist in making plan eligibility and coverage determinations, or for utilization review activities.

For health care operations purposes, such use and disclosure may take place in a number of ways involving plan administration, including for quality assessment and improvement, vendor review, and underwriting activities. Your information could be used, for example, to assist in the evaluation of one or more vendors who support us, or you may be contacted to provide reminders or information about treatment alternatives or other health-related benefits and services available under the plan.

Your protected health information may also be disclosed to Bank of America associates who are involved in plan administration in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose your protected health information to Bank of America in connection with payment, treatment or health care operations.

In addition, the plan may use or disclose your protected health information without your authorization under conditions specified in federal regulations, including:

- As required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law
- For public health activities
- Disclosures to an appropriate government authority regarding victims of abuse, neglect or domestic violence
- To a health oversight agency for oversight activities authorized by law
- In connection with judicial and administrative proceedings
- To a law enforcement official for law enforcement purposes
- To a coroner or medical examiner
- To cadaveric organ, eye or tissue donation programs
- For research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to health or safety
- For specialized government functions (e.g., military and veterans activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- For workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.

The plan may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, protected health information that is directly relevant to the person's involvement with your care or payment related to your care. In addition, the plan may use or disclose the protected health information to notify a member of your family, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location,

general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, the plan will do what, in its judgment, is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your health care.

Other uses and disclosures that are not permitted under the federal regulations will be made only with your written authorization, and you may revoke your authorization in writing at any time.

You may ask the plan to restrict uses and disclosures of your protected health information to carry out treatment, payment, or health care operations, or to restrict uses and disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, the plan is not required to agree to your request. You may exercise this right by contacting the Personnel Center and you will be provided with additional information.

You have the right to request the following with respect to your protected health information: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of certain disclosures of this information by the plan (you are not entitled to an accounting of disclosures made for payment, treatment or health care operations, or disclosures made pursuant to your written authorization); and (iv) the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

You have the right to request in writing that you receive your protected health information by alternative means or at an alternative location if you reasonably believe that disclosure could pose a danger to you.

Bank of America reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information maintained by the plan. If this notice is changed, you will receive a new notice.

If you believe that your privacy rights have been violated, you may complain to the plan in writing at the location described below under "Additional information" or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. You will not be retaliated against for filing a complaint.

Additional information

For further information, contact the Personnel Center.

Legacy Bank of America associates may also write to:

Bank of America Personnel Center
FL0-707-01-07
2300 Discovery Drive
PO Box 785026
Orlando, FL 32878-5026

Legacy Fleet associates may also write to:

Bank of America Personnel Center
Continental United States
PO Box 770003
Cincinnati, OH 45277-0071

Health and wellness

Health care benefits



Medical coverage

Bank of America offers the following medical plans:

- **Health maintenance organizations (HMOs)/exclusive provider organizations (EPOs)**
 - Aetna Select EPO
 - Blue Cross Blue Shield EPO*
 - Regional HMOs/EPOs
- **Preferred provider organizations (PPOs)**
 - Aetna Choice II PPO
 - Blue Cross Blue Shield PPO*
- **Non-network (indemnity) plans**
 - Blue Cross Blue Shield High Deductible*
 - Blue Cross Blue Shield Out-of-Area* (only available if you do not live in a PPO network area).

Each type of plan reflects a different type of coverage. The specific medical plan options available to you are determined by your home ZIP code (not your work location) and are listed in your enrollment materials. Some options may be available in one location, but not another.

This handbook contains detailed information about the benefits provided by the medical plans that are listed in **Figure 3.0**. For more detailed information about these plans, see the sections from “Benefit coverage under the medical plans listed in Figure 3.0” through “Reimbursement for services for the medical plans listed in Figure 3.0” later in this “Medical coverage” section.

If you enroll in a regional medical HMO/EPO that is not listed in **Figure 3.0**, you should receive detailed information about plan benefits directly from that plan. You may also obtain information by contacting that plan directly at the telephone number listed in your enrollment materials.

If you are a global assignee whose home country is the United States, you have two medical plan choices:

- Aetna Global \$300 Indemnity
- Aetna Global \$1,500 Indemnity.

The benefits through these plans are described in the Summary of Coverage booklet provided to you by Aetna Global. A brief summary of these plans is contained in the enrollment materials you receive. Additional information can be obtained from Aetna Global at the telephone number also included in your annual enrollment materials or online at www.aetna.com/agb. You will then be prompted to register on the Web site.

Here are descriptions of the main features of Bank of America’s medical plans.

Health maintenance organizations (HMOs) or exclusive provider organizations (EPOs)

HMO/EPO plans are available to associates and their eligible dependents who live within the plan’s geographic service area defined by home ZIP code.

As a full-time or part-time associate, each year during the annual enrollment period you will receive information that identifies the plans available in your home ZIP code.

*Administered by Blue Cross Blue Shield of Georgia

Figure 3.0**Medical plans for which detailed benefits information can be found in this handbook****Plan names**

Aetna Select EPO
 Aetna Choice II PPO
 Blue Cross Blue Shield Florida BlueCare HMO
 Blue Cross Blue Shield EPO*
 Blue Cross Blue Shield PPO*
 Blue Cross California PPO*
 Blue Cross Blue Shield Out-of-Area*
 Blue Cross Blue Shield High Deductible*
 BlueChoice HMO Georgia*
 CIGNA Open Access HMO
 Companion HMO South Carolina
 Harvard Pilgrim HMO
 Independent Health EPO
 MVP Select Care EPO
 Optima Health HMO Virginia
 Premera Blue Cross Foundation EPO
 Presbyterian EPO New Mexico
 Tufts Health Plan Open Access EPO
 United Choice EPO

*Administered by Blue Cross Blue Shield of Georgia

Figure 3.0.1**Medical plans for which detailed benefits information cannot be found in this handbook
*(Contact the plan for more information)*****Plan names**

Blue Shield HMO Access+ Northern and Southern California
 Capital Health HMO Tallahassee
 Group Health Coop HMO East & West
 Health Plan Nevada HMO
 HealthNet HMO Northern and Southern California
 Blue Cross Blue Shield HMO Illinois
 HMSA Hawaii PPO
 Kaiser HMO Georgia (and CCO)
 Kaiser HMO Hawaii
 Kaiser HMO Mid-Atlantic
 Kaiser HMO Northwest
 Kaiser HMO Northern & Southern California
 Scott & White HMO

Health and wellness

Health care benefits

Plan participants have access to a network of participating primary care physicians (PCPs), specialists and hospitals that meet the specific health plans' strict requirements for quality and service. The network physicians and facilities are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training. In general, no benefits are provided by the HMO/EPO if you receive care from non-network providers and facilities.

(Exceptions apply if you are referred to a non-network specialist with your plan's approval or if you need emergency care outside the HMO/EPO service area.) Emergency care will be covered at non-network facilities within the service area, until the patient can be stabilized and moved to a network facility.

In general, most of the HMO/EPO plans do not require you to choose a primary care physician. Plans that do require a PCP election are noted in your enrollment materials. Even if your plan does not require you to choose a PCP, it is a good idea to select one as he/she can serve as your guide to care in today's complex medical system and can coordinate and monitor your overall care.

The primary care physician (PCP)

If your plan requires you to choose a PCP, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, will refer you to other doctors or facilities for treatment. To receive coverage for such services, you must have a prior referral from your PCP for all non-emergency services and any necessary follow-up.

The referral is important because:

- It is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment.
- You may be responsible for billed services if no referral is obtained.

Important note: Physicians are added to and deleted from the provider groups during the year, so it is always important to call your medical plan claims administrator to verify that a physician is in the network.

Primary and preventive care

HMOs/EPOs typically cover preventive physical exams, well-baby care, immunizations and allergy shots. You are responsible only for the copayment shown in **Figure 3.1**.

Specialty and facility care

Your doctor may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. If your plan requires you to choose a PCP, you must have a prior referral from your PCP in order to receive coverage for any services the specialist or facility provides. Even if your plan requires you to choose a PCP, you may generally obtain preventive gynecological exams from participating providers without a referral. If your plan does not require you to choose a PCP, you are responsible for ensuring network status of the provider or facility to which you have been referred.

You will be responsible for the copayment shown in **Figure 3.1** for any care you receive from a participating specialist or facility for covered services.

To avoid costly and unnecessary bills, follow these steps:

- Always consult your PCP first when you need medical care. If he or she deems it medically necessary, you will get a referral to a participating specialist or facility (if required). The referral process varies among medical plan claims administrators. In general, if your HMO/EPO requires you to choose a PCP, you will need written referrals to see a specialist. The referral may be good only for a specified length of time and number of visits. If the specialist says you need additional visits or another referral, the specialist may need to contact your PCP or health plan for authorization. It is always a good idea to check with your medical plan claims administrator on how the referral process works for your health plan.
- Review the referral with your PCP. Understand what specialist services are being recommended and why.
- Any additional treatments or tests that are covered benefits may require another referral from your PCP. The referral may be necessary to have these services approved for payment. Without the referral, you may be responsible for payment of these services.
- Generally, out-of-network emergency care is covered, although special provisions may apply. Contact the health plan for details.
- If it is not an emergency and you go to another doctor or facility without your PCP's prior referral, you have to pay the bill yourself. You may also be responsible for payment in full for these services.

- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require your PCP or specialist to give prior notice and/or receive preauthorization from your health plan. When properly authorized, these services are covered after the applicable copayment.

Certain inpatient and outpatient services require preauthorization or prior notification to your health plan by your PCP or specialist or benefits may not be payable. You must ensure that you or your physician calls to obtain preauthorization or give prior notification. See the list of services requiring prior authorization in **Figure 3.2.1**.

Remember, you cannot request referrals after you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from your health plan (when applicable) before seeking specialty or hospital care. HMOs/EPOs sometimes differ in the services they provide. If you are considering an HMO/EPO, be sure to review the services it does and does not provide.

Details of the benefits and services covered through the Aetna Select EPO, Blue Cross Blue Shield EPO and the regional HMOs/EPOs listed in **Figure 3.0** are described later in this section. If you are enrolled in a regional HMO/EPO not listed in **Figure 3.0**, you can call that plan's member services department and request details of the benefits and services covered that describe:

- The nature of the services provided by the plan
- Conditions of eligibility to receive services
- Circumstances that may result in a denial of benefits
- Procedures you should follow to obtain services
- The procedures for review of denied services.

To help you make your selection, you may obtain listings of participating providers by requesting information from the plan. If your doctor is not included in the provider listing, you may call the health plan's member services or your doctor's office directly to determine whether he or she participates in the plan.

Preferred provider organizations (PPOs)

- A PPO provides care through a network of providers.
- You can choose a network provider and receive a higher benefit.
- You can choose a non-network provider and still receive a benefit, but at a lower percentage.
- You are not required to select a primary care physician (PCP).
- You pay a flat fee (copayment) for some services, including in-network office visits.
- Deductibles and some out-of-pocket expenses will apply.

A PPO is a network of doctors and hospitals that have agreed to provide quality medical care and services at negotiated rates. Associates will receive a higher reimbursement for using services provided by a participating doctor or hospital.

Any associate whose home ZIP code is within the geographic service area of a participating provider is considered to live in a network area. To see if you are in a network area, refer to your enrollment materials or call your health plan directly.

How PPO plans work

In-network coverage

To receive in-network benefits, the highest level of coverage, you must use a participating provider. However, you don't have to choose a primary care physician to direct your care.

- Some services are subject to an annual deductible.
- You pay a copayment for office visits, preventive care and prescription drugs.
- You have no claim forms to file.
- You get a wide range of benefits including regular check-ups, well-baby care, well-woman exams and immunizations.

Note that physicians are added and deleted during the year, so it is important to call your medical plan claims administrator to verify if a physician is in the network.

The Aetna and Blue Cross Blue Shield PPO networks include a wide range of doctors representing all essential specialties. If specialty care becomes necessary, you may ask your primary physician to refer you to a specialist, or you can choose your own.

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If a physician in your PPO network refers you to a specialist, it is your responsibility to check with your medical plan claims administrator to be sure the specialist is a network provider. You will not receive the higher network PPO benefits because a PPO doctor referred you, unless the specialist is also in the PPO network.

Many radiologists, anesthesiologists and pathologists are not part of the PPO network, even though their services may be provided at a PPO hospital. The PPO plans will still pay 80% of the covered reasonable and customary expenses, subject to the deductible for radiologists, anesthesiologists and pathologists, when services are provided at a network facility.

Clinics or centers (for example, outpatient, psychiatric, women's, etc.) that are on the same grounds or near a PPO hospital may not be directly associated with the hospital. You will be reimbursed at the lower out-of-network benefit rate if you use a facility that is not a PPO network provider, regardless of its location.

Out-of-network coverage

The PPO plans also provide benefits when you use non-network providers. With your out-of-network benefits, you can see any doctor you like. However, a number of coverage limits apply. You won't be covered for the same range of services as with a network provider. And you will have to pay a higher deductible and receive a lower percentage of reimbursement. Also, if you choose to go into a non-network

hospital, you must obtain inpatient preadmission certification from your medical plan claims administrator by calling the toll-free number on your plan ID card. If you do not obtain preadmission certification, you will be responsible for the first \$500 of covered hospital expenses in addition to the other required coinsurance payments and deductibles. If the medical plan claims administrator determines your hospitalization not to have been medically necessary and, therefore, does not approve the request, no benefits will be paid.

The following are characteristics of out-of-network coverage:

- You pay a higher annual deductible for all covered services.
- You are responsible for a higher out-of-pocket maximum for all covered services.
- You pay a greater percentage of the charges for covered services.
- You will not have the advantage of lower negotiated rates for services rendered. The plan will base payment on reasonable and customary limits. Any charges higher than reasonable and customary will be your responsibility.
- You must submit a claim form.
- Your non-emergency inpatient hospitalizations require you to obtain preadmission certification.
- Your emergency inpatient hospitalizations require precertification within 48 hours of admission; however, if you are admitted on a Friday or Saturday, this period will be extended to 72 hours.

Non-network (indemnity) plans

The following are characteristics of the non-network (indemnity) plans:

- There is no network of providers.
- You may choose any licensed and eligible provider for care.
- You must submit a claim form unless you are seeing a Blue Cross Blue Shield provider. A Blue Cross Blue Shield provider will submit your claims for you.
- Non-emergency inpatient hospitalizations require preadmission certification.
- Emergency inpatient hospitalizations require precertification within 48 hours of admission; however, if you are admitted on a Friday or Saturday, this period will be extended to 72 hours.
- You must satisfy a deductible and pay coinsurance for covered services.
- Preventive care is covered as described in **Figure 3.2**.

Currently, not all Bank of America associates live in areas where HMO/EPO or PPO networks are available. For this reason, the company offers the Blue Cross Blue Shield out-of-area indemnity plan option to those associates that do not have access to networks. All associates (except for residents of Hawaii) may enroll in the Blue Cross Blue Shield high deductible indemnity plan. These plans are administered by Blue Cross Blue Shield of Georgia.

Note: You do not have to use Blue Cross Blue Shield providers if you are enrolled in one of these plans. However, if you do use Blue Cross Blue Shield preferred providers, you can take advantage of the provider's negotiated rate for network members and reduce your out-of-pocket expenses.

The description of covered and noncovered services, supplies and equipment, as well as all definitions and provisions (except references to in-and out-of-network and special negotiations to the contrary), apply to the non-network plans in the same way they apply to the PPO plans. See **Figure 3.2** for a list of services covered under these plans.

Health care advocates

Health care advocates are for associates and their dependents who are enrolled in Aetna Select EPO, Aetna Choice II PPO and all of the plans administered by Blue Cross Blue Shield of Georgia, including the Blue Cross Blue Shield PPO plan, the Blue Cross Blue Shield out-of-area plan, the Blue Cross Blue Shield high-deductible plan and the BlueChoice HMO Georgia. Health care advocates are registered nurses employed by Aetna and Blue Cross Blue Shield. Health care advocates will contact participants to provide information and assistance, primarily when a participant has a:

- Chronic disease such as diabetes or asthma
- Complex or catastrophic medical condition, such as one involving an unplanned hospitalization
- Planned hospital admission for treatment or surgery
- Medical condition that is considered high risk.

Health care advocates can help participants:

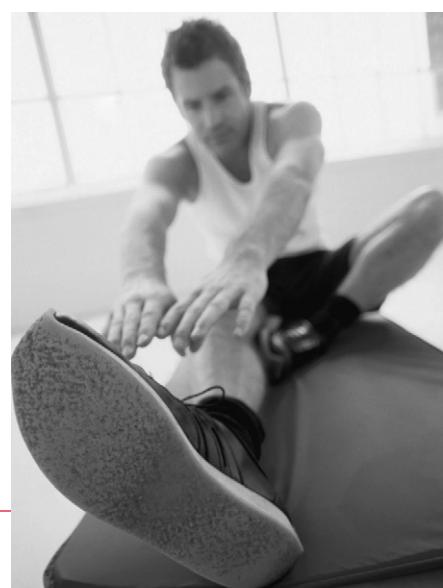
- Explore treatment options
- Understand and manage chronic conditions
- Understand and follow through with treatment plans, medications and therapies
- Prepare for hospitalization and cope with recovery.

Health care advocates are not a substitute for a primary care physician or specialist. Use of their services is voluntary. All information discussed with a health care advocate is completely confidential.

Benefit coverage under the medical plans listed in Figure 3.0

Figures 3.1 and **3.2** provide an overview of the benefit coverage under the medical plans listed in **Figure 3.0**.

Figures 3.1 and **3.2** do not list all exclusions and limitations under these plans. For definitions, covered services, exclusions and limitations and other provisions for these plans, refer to the sections from “Provisions and definitions for the medical plans listed in Figure 3.0” through “Reimbursement for services for the medical plans listed in Figure 3.0” that follow this section.



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Figure 3.1

The following chart depicts the standard plan design for the PPO and HMO/EPO options. Some benefits vary for regional HMO/EPO plans; where exceptions are noted, refer to **Figure 3.1.1** for more information.

Network plan summaries			
Type of service or supply	Aetna Choice II PPO Blue Cross Blue Shield PPO		Aetna Select EPO Blue Cross Blue Shield EPO and Regional HMOs/EPOs listed in Figure 3.0
	In-network	Out-of-network	
Lifetime maximum	Unlimited	Unlimited	Unlimited
Precertification			
Precertification required for all inpatient admissions and some other services. See Figure 3.2.1 for each plan's list of precertification requirements.	Must precertify: hospital admissions; other services may not be covered if not precertified	Must precertify: hospital admissions — \$500 penalty per occurrence if not precertified; other services may not be covered if not precertified	Precertification requirements vary by plan; see Figure 3.2.1 for precertification requirements
Extended family benefits			
Domestic partner (same or opposite gender)	Yes	Yes	Yes
Other adult dependent	Yes	Yes	Yes
Calendar year deductible¹			
Per person	\$300	\$600	N/A
Per family	\$600	\$1,200	N/A
Out-of-pocket maximum (includes deductible)			
Per person	\$2,500	\$5,000	N/A
Per family	\$5,000	\$10,000	N/A
Primary and preventive care			
Office visits — Primary physician	100% after \$15 copay per visit	60% covered after deductible	100% after \$15 copay per visit
Office visits — Specialist	100% after \$25 copay per visit	60% covered after deductible	100% after \$25 copay per visit ²
Office surgery	100% after the following copays: \$15 copay — PCP office visit \$25 copay — Specialist office visit	60% covered after deductible	100% after the following copays: \$15 copay — PCP office visit \$25 copay — Specialist office visit ²
Pediatric examinations	\$15 copay; frequency of covered exam according to health plan schedule	60% covered after deductible; frequency of covered exam according to health plan schedule	\$15 copay; frequency of covered exam according to health plan schedule
Preventive examinations	100% after office visit copay; one preventive exam per calendar year	60% covered after deductible; one preventive exam per calendar year	100% after office visit copay per visit, one preventive exam per calendar year
Preventive child and well-baby care	100% after office visit copay, according to health plan schedule	60% covered after deductible; according to health plan schedule	100% after office visit copay, according to health plan schedule
Immunizations	100% after office visit copay; frequency of covered immunizations according to health plan schedule	60% covered after deductible; frequency of covered immunizations according to health plan schedule	100% after office visit copay; frequency of covered immunizations according to health plan schedule

Network plan summaries			
Type of service or supply	Aetna Choice II PPO Blue Cross Blue Shield PPO		Aetna Select EPO Blue Cross Blue Shield EPO and Regional HMOs/EPOs listed in Figure 3.0
	In-network	Out-of-network	
Primary and preventive care (continued)			
Well-woman exam (includes Pap)	100% after office visit copay; frequency of covered exam according to health plan schedule	60% covered after deductible; frequency of covered exam according to health plan schedule	100% after office visit copay — direct access (no referral) to participating providers; frequency of covered exam according to health plan schedule
Preventive mammogram	100% after office visit copay if in physician's office (one preventative mammogram per calendar year for women age 35 and over; coverage available prior to age 35 if medically necessary)	60% after deductible; (one preventative mammogram per calendar year for women age 35 and over; coverage available prior to age 35 if medically necessary)	100% after office visit copay (one preventative mammogram per calendar year for women age 35 and over; coverage available prior to age 35 if medically necessary)
Preventive lab and X-ray performed in a physician's office	100%; after office visit copay; waive copay if no physician visit	60% after deductible	100%; after office visit copay; waive copay if no physician visit
Preventive lab and X-ray performed in an independent lab	100%; no deductible	60% after deductible	Covered at 100%
Exclusions and limitations			
Preventive eye examinations	Not covered; routine vision care available through Bank of America vision care plans	Not covered; routine vision care available through Bank of America vision care plans	Not covered; routine vision care available through Bank of America vision care plans
Examination for the treatment of a medical eye condition, disease, injury to the eye, cataract surgery (SPC) and/or orthoptic training	100% after PCP or specialist copay	60% after deductible	100% after PCP or specialist copay ²
Specialty and outpatient care			
Office visits	100% after office visit copay	60% after deductible	100% after office visit copay ³
Diagnostic lab and X-ray performed in a physician's office	100% after office visit copay; waive copay if no physician visit	60% after deductible	100% after office visit copay; waive copay if no physician visit
Diagnostic lab and X-ray performed in an independent lab	80% after deductible	60% after deductible	Covered at 100%
Outpatient surgery	80% after deductible	60% after deductible	100% after the following copays: \$25 copay — specialist's office \$50 copay — outpatient facility ²
Allergy testing (diagnosis and follow-up)	100%; office visit copay may apply	60% after deductible	100%; office visit copay may apply ^{4, 5}
Allergy treatment, preventive injections, with or without physician encounter	100%; office visit copay may apply	60% after deductible	100%; office visit copay may apply
Therapy (speech, occupational, physical)	80% after deductible; up to 90 combined in- and out-of-network visits per calendar year (therapy for developmental delay covered through age six)	60% after deductible; up to 90 combined in- and out-of-network visits per calendar year (therapy for developmental delay covered through age six)	100% after \$25 copay ² per visit; up to 90 visits per calendar year for all therapies combined (therapy for developmental delay covered through age six)

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Network plan summaries			
Type of service or supply	Aetna Choice II PPO Blue Cross Blue Shield PPO		Aetna Select EPO Blue Cross Blue Shield EPO and Regional HMOs/EPOs listed in Figure 3.0
	In-network	Out-of-network	
Specialty and outpatient care (continued)			
Chiropractic services (muscular skeletal manipulation)	80% after deductible; up to 20 combined in- and out-of-network visits per calendar year for acute conditions	60% after deductible; up to 20 combined in- and out-of-network visits per calendar year for acute conditions	100% after \$25 copay per visit; up to 20 visits per calendar year ²
Skilled nursing facilities	80% after deductible; up to 100 combined in- and out-of-network days per calendar year	60% after deductible; up to 100 combined in- and out-of-network days per calendar year	100% after \$250 copay per admission (waived if member is transferred from a hospital ⁶); no visit limit; prior authorization required
Home health care	80% after deductible; up to 120 combined in- and out-of-network visits per calendar year	60% after deductible; up to 120 combined in- and out-of-network visits per calendar year	Covered at 100%; no visit limit, subject to authorization ⁶
Hospice care	80% after deductible; bereavement counseling limited to 15 sessions per family within 12 months of death	60% after deductible; bereavement counseling limited to 15 sessions per family within 12 months of death	Covered at 100% after \$250 copay per admission (waived if member is transferred from a hospital); prior authorization required; \$15 copay or 100% outpatient for bereavement counseling (up to 15 visits per family within 12 months of death) ⁷
Durable medical equipment	80% after deductible	60% after deductible	Covered at 100%
External prosthetic devices	80% after deductible	60% after deductible	Covered at 100%
Services for the disorder of the temporomandibular (jaw) joint (TMJ)	100% after office visit copay if performed in physician's office; otherwise, 80% after deductible when medically necessary; excluding crowns, inlays, bridgework and appliances	60% after deductible when medically necessary, excluding crowns, inlays, bridgework and appliances	100% after office visit copay — subject to medical necessity; coverage excludes crowns, inlays, bridgework and appliances ⁸
Prescription drugs — Coverage provided through Caremark²			
Retail (up to a 30-day supply)	\$10 copay — generic; \$20 copay — preferred brand-name drugs; \$40 copay — non-preferred brand name drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between brand name and generic drug costs	Nonparticipating pharmacy — covered at 60% for generic; member requesting brand name drug when generic is available is responsible for difference between generic and brand cost, then plan pays 60%	\$10 copay — generic; \$20 copay — preferred brand name drugs; \$40 copay — non-preferred brand name drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between brand name and generic drug costs
Mail order (up to a 90-day supply)	\$20 copay — generic; \$40 copay — preferred brand name drugs; \$80 copay — non-preferred brand name drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between the brand name and generic drug costs	Not covered	\$20 copay — generic; \$40 copay — preferred brand name drug; \$80 copay — non-preferred brand name drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between the brand name and generic drug costs

Network plan summaries			
Type of service or supply	Aetna Choice II PPO Blue Cross Blue Shield PPO		Aetna Select EPO Blue Cross Blue Shield EPO and Regional HMOs/EPOs listed in Figure 3.0
	In-network	Out-of-network	
Prescription drugs — Coverage provided through Caremark² (continued)			
Contraceptives	Contraceptives covered at applicable copays	Not covered	Contraceptives covered at applicable copays
Infertility drugs	Fertility drugs covered at applicable copay; limited to \$10,000 lifetime maximum; there is a separate \$10,000 lifetime maximum for medical services related to infertility	Not covered	Fertility drugs covered at applicable copay; limited to \$10,000 lifetime maximum; there is a separate \$10,000 lifetime maximum for medical services related to infertility
Inpatient services			
Room and board	80% after deductible	60% after deductible	100% after \$250 copay per admission
Physician charges	80% after deductible	60% after deductible	Covered at 100%
X-rays and lab tests	80% after deductible	60% after deductible	Covered at 100%
Special care unit	80% after deductible	60% after deductible	Covered at 100%
Hospice facility	80% after deductible	60% after deductible	Covered at 100% after \$250 copay per admission (waived if member is transferred from a hospital) ⁶
Emergency care			
Urgent care facility	At urgent care facility, 100% after \$50 copay; no coverage for non-urgent use	60% after deductible; no coverage for non-urgent use	At urgent care facility, 100% after \$50 copay; no coverage for non-urgent use ²
Emergency room	80% after deductible for medical emergency	80% after deductible for medical emergency	100% after \$50 copay (waived if admitted); no coverage for non-emergency use (in or out of area) ⁶
Ambulance	80% after deductible for medical emergency	80% after deductible for medical emergency	100% coverage if medical emergency or authorized by the PCP (for plans that require PCP authorization)
Maternity care			
Pre/post natal care	80% after deductible (initial visit to determine pregnancy covered at 100% after office visit copay)	60% after deductible	\$15 copay for the first obstetric visit to delivering physician ⁶
Maternity care	80% after deductible	60% after deductible	Covered at 100% after \$250 copay per admission
Nursery charges	80% after deductible	60% after deductible	Covered at 100% after \$250 copay per admission for non well-baby charges
Birthing centers	80% after deductible	60% after deductible	Covered at 100% after \$250 copay per admission

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Health care benefits

Network plan summaries					
Type of service or supply	Aetna Choice II PPO Blue Cross Blue Shield PPO			Aetna Select EPO Blue Cross Blue Shield EPO and Regional HMOs/EPOs listed in Figure 3.0	
	In-network	Out-of-network			
Family planning					
Services that are not subject to the \$10,000 infertility lifetime maximum:					
Infertility (diagnosis and treatment of the underlying medical cause)	100% after office visit copay if performed in physician's office; otherwise, 80% after deductible	60% after deductible	100% after applicable copay per visit		
Lab, X-rays and office visits related to family planning	100% after office visit copay if performed in physician's office; otherwise, 80% after deductible	60% after deductible	100% after applicable copay per visit		
Sterilization	100% after office visit copay if performed in physician's office; otherwise, 80% after deductible	60% after deductible	100% after applicable copay per visit		
Abortion	100% after office visit copay if performed in physician's office; otherwise, 80% after deductible	60% after deductible	100% after applicable copay per visit		
Services that are subject to the \$10,000 infertility lifetime maximum:					
Artificial insemination	100% after office visit copay if performed in physician's office; otherwise, 80% after deductible	60% after deductible	100% after applicable copay per visit		
In vitro fertilization/GIFT/ZIFT/ovum transplants⁶	100% after office visit copay if performed in physician's office; otherwise, 80% after deductible	60% after deductible	100% after applicable copay per visit ⁹		
Charges associated with cryopreserved embryos and sperm	100% after office visit copay if otherwise, 80% after deductible	60% after deductible	100% after applicable copay per visit ²		
Exclusions and limitations					
Reversal of sterilization	Not covered	Not covered	Not covered		
Purchase of donor sperm and any charges for the storage of sperm	Not covered	Not covered	Not covered ⁹		
Purchase of donor eggs and any charges associated with the care of the donor required for donor egg retrievals or transfers or gestational carriers	Not covered	Not covered	Not covered ⁹		
Mental health/chemical dependency — Coverage provided through CIGNA Behavioral Health¹⁰					
Inpatient treatment	100% after \$250 deductible; up to 90 days per calendar year	60% of R&C; up to 30 days per calendar year	In-Network 100% after \$250 deductible; up to 90 days per calendar year	Out-of-Network 60% of R&C; up to 30 days per calendar year	
Outpatient treatment	100% after \$15 copay per visit; up to 90 visits per calendar year	60% of R&C; up to 30 visits per calendar year	100% after \$15 copay per visit; up to 90 visits per calendar year	60% of R&C; up to 30 visits per calendar year	

Figure 3.1.1

This chart notes exceptions to the standard plan design provisions listed in **Figure 3.1**. Unless otherwise noted here, the plans below use the standard provisions listed in **Figure 3.1** (under the column “Aetna Select EPO Blue Cross Blue Shield HMO/EPO and Regional HMOs/EPOs listed in Figure 3.0”). For more coverage information, contact your plan.

Plan name	Exceptions to standard plan design provisions for Regional HMOs/EPOs
Blue Cross Blue Shield Florida BlueCare HMO	<ul style="list-style-type: none"> Specialty and outpatient care office visits: Standard copays apply for contracting provider; non-contracting provider is 40% of allowance Skilled nursing facilities: Copay for admission always waived Home health care: Coordinated through the PCP but visit is generally conducted by home health service provider Hospice care: Prior authorization is required; covered at 100% after \$15 copay for PCP visit; \$25 copay for specialist visit TMJ: \$15 copay for PCP visit; \$25 copay for specialist visit Emergency room: All care provided at an emergency room facility is covered as emergency use Pre/post natal care: \$25 copay for the initial visit to physician's office for pre/postnatal; referral required; 100% for remaining visits thereafter Infertility: Ovum transplants not covered Mental health/chemical dependency: \$250 copay per inpatient admission (limit of 30 inpatient days per calendar year); \$15 copay for outpatient mental health treatment up to 20 visits per year; \$15 copay outpatient substance dependency treatment up to 20 visits per year; detox covered on inpatient basis only; no coverage for out-of-network care
Companion HMO South Carolina	<ul style="list-style-type: none"> Hospice care: Bereavement counseling is not covered. Mental health/chemical dependency: \$250 annual deductible for inpatient admission (limited to 90 days per calendar year combined with chemical dependency); \$15 copay for outpatient visits (limited to 90 visits per calendar year combined with chemical dependency); no coverage for out-of-network care
Independent Health EPO	<ul style="list-style-type: none"> Allergy testing: No copayment for testing Hospice care: No authorization required for Hospice except advance care planning
Harvard Pilgrim HMO	<ul style="list-style-type: none"> Infertility: If medical criteria is met and approved, donor sperm and donor eggs are covered as part of benefit. TMJ: Coverage for medical treatment of temporomandibular joint dysfunction
Optima Health HMO Virginia	<ul style="list-style-type: none"> Mental health/chemical dependency: \$250 annual deductible (limited to 90 days per calendar year combined with chemical dependency); \$15 copay for outpatient visits (limited to 90 visits per calendar year combined with chemical dependency); no coverage for out-of-network care
Premera Blue Cross Foundation EPO	<ul style="list-style-type: none"> Specialist visits: Copay for all specialist visits is \$15. Eye care: \$15 copay for eye care office visits (for medical conditions only) Chiropractic services: \$15 copay; limited to 20 chiropractic visits per year Prescription drugs: Coverage offered by Premera (as provided through Medco) Allergy testing: \$15 copay per visit Urgent care facility: \$15 copay; no coverage for non-urgent use Mental health/chemical dependency: \$250 annual deductible (limited to 90 days per calendar year combined with chemical dependency); \$15 copay for outpatient visits (limited to 90 visits per calendar year combined with chemical dependency); no coverage for out-of-network care Therapy: \$15 copay for speech, occupational and physical therapy limited to (90 days per calendar year combined for all therapies) Skilled nursing facility: Inpatient copay does not apply. Hospice inpatient care: Inpatient copay applies even when transferred from another facility. Infertility treatment: Charges associated with cryopreservation or storage of cryopreserved embryos and sperm are not covered. Bereavement counseling: Not covered
Presbyterian EPO (NM)	<ul style="list-style-type: none"> Mental health/chemical dependency: \$250 annual deductible (limited to 90 days per calendar year combined with chemical dependency); \$15 copay for outpatient visits (limited to 90 visits per calendar year combined with chemical dependency); no coverage for out-of-network care

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Figure 3.2

Note: You do not have to use Blue Cross Blue Shield providers if you are enrolled in one of these non-network (indemnity) plans. However, if you do use Blue Cross Blue Shield preferred providers, you can take advantage of the provider's negotiated rates for network members and reduce your out-of-pocket expenses.

Non-network plan summaries		
Type of service or supply	Blue Cross Blue Shield Out-of-Area Indemnity Plan	Blue Cross Blue Shield High Deductible Plan
Lifetime maximum	Unlimited	Unlimited
Precertification		
Precertification required for all inpatient admissions and some other services. See Figure 3.2.1 for each plan's list of precertification requirements.	Must precertify: Hospital admissions — \$500 penalty per occurrence if not precertified; other services may not be covered if not precertified	Must precertify: Hospital admissions — \$500 penalty per occurrence if not precertified; other services may not be covered if not precertified
Extended family benefits		
Domestic partner (same or opposite sex)	Yes	Yes
Other adult dependent	Yes	Yes
Calendar year deductible		
Per person	\$300	\$1,500
Per family	\$600	\$3,000
Out-of-pocket maximum		
Per person	\$2,000	\$5,000
Per family	\$4,000	\$10,000
Primary and preventive care		
Physician office visits	80% after deductible	80% after deductible
Office surgery	80% after deductible	80% after deductible
Preventive examinations	100%; frequency of covered exam according to health plan schedule	80%; frequency of covered exam according to health plan schedule, subject to a \$250 per person annual maximum for combined wellness services (not subject to deductible)
Preventive child and well-baby care	100%; frequency of covered exam according to health plan schedule	Covered as part of preventive exam benefit
Immunizations	100%; frequency of covered immunization according to health plan schedule	Covered as part of preventive exam benefit
Well-woman exam	100%; frequency of covered exam according to health plan schedule	Covered as part of preventive exam benefit
Preventive mammogram	100% (one annual preventive mammogram for women age 35 and over; coverage available prior to age 35 if medically necessary)	Covered as part of preventive exam benefit (one annual preventive mammogram for women age 35 and over; coverage available prior to age 35 if medically necessary)
Preventive lab and X-ray	80% after deductible	Covered as part of preventive exam benefit
Primary and preventive care (exclusions and limitations)		
Preventive eye examinations	Not covered; routine vision care available through Bank of America vision care plans	Not covered; routine vision care available through Bank of America vision care plans

Non-network plan summaries		
Type of service or supply	Blue Cross Blue Shield Out-of-Area Indemnity Plan	Blue Cross Blue Shield High Deductible Plan
Specialty and outpatient care		
Office visits	80% after deductible	80% after deductible
Outpatient surgery	80% after deductible	80% after deductible
Allergy testing (diagnosis and follow-up)	80% after deductible	80% after deductible
Allergy treatment (preventive injections at physician's office, with or without physician encounter)	80% after deductible	80% after deductible
Diagnostic mammogram	80% after deductible	80% after deductible
Diagnostic X-ray and lab tests	80% after deductible	80% after deductible
Therapy (speech, occupational and physical)	80% after deductible; up to 90 combined visits per calendar year (therapy for developmental delay covered through age 6)	80% after deductible; up to 90 combined visits per calendar year (therapy for developmental delay covered through age 6)
Chiropractic services (muscular skeletal manipulation)	80% after deductible; up to 20 visits per calendar year	80% after deductible; up to 20 visits per calendar year
Skilled nursing facility	80% after deductible; up to 100 days per year	80% after deductible; up to 100 days per year
Home health care	80% after deductible; up to 120 visits per year	80% after deductible; up to 120 visits per year
Hospice care	80% after deductible; bereavement counseling limited to 15 sessions per family within 12 months of death	80% after deductible; bereavement counseling limited to 15 sessions per family within 12 months of death
Durable medical equipment	80% after deductible	80% after deductible
External prosthetic devices	80% after deductible	80% after deductible
Services for the disorder of the temporomandibular (jaw) joint (TMJ)	80% after deductible when medically necessary, excluding crowns, inlays, bridgework and appliances	80% after deductible when medically necessary, excluding crowns, inlays, bridgework and appliances
Prescription drugs — Coverage provided through Caremark		
Retail	\$10 copay — generic; \$20 copay — preferred brand name drugs; \$40 copay — non-preferred brand name drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between the brand name and generic drug costs	\$10 copay — generic; \$20 copay — brand name formulary drugs; \$40 copay — brand name non-formulary drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between the brand name and generic drug costs
Mail order	\$20 copay — generic; \$40 copay — preferred brand name drugs; \$80 copay — non-preferred brand name drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between the brand name and generic drug costs	\$20 copay — generic; \$40 copay — preferred brand name drugs; \$80 copay — non-preferred brand name drugs; member requesting brand name drug when generic is available is responsible for brand copay plus the difference between the brand name and generic drug costs
Contraceptives	Contraceptives covered at applicable copays	Contraceptives covered at applicable copays

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Non-network plan summaries		
Type of service or supply	Blue Cross Blue Shield Out-of-Area Indemnity Plan	Blue Cross Blue Shield High Deductible Plan
Inpatient services		
Room and board	80% after deductible	80% after deductible
Physician charges	80% after deductible	80% after deductible
Lab and X-rays	80% after deductible	80% after deductible
Special care unit	80% after deductible	80% after deductible
Hospice facility	80% after deductible	80% after deductible
Emergency care		
Emergency room	80% after deductible for true medical emergency; no coverage for non-emergency use	80% after deductible for true medical emergency; no coverage for non-emergency use
Urgent care facility	80% after deductible	80% after deductible
Ambulance	80% after deductible for medical emergency	80% after deductible for medical emergency
Maternity care		
Prenatal	80% after deductible	80% after deductible
Nursery charges	80% after deductible	80% after deductible
Birthing center	80% after deductible	80% after deductible
Family planning		
Services that are not subject to the \$10,000 infertility lifetime maximum		
Infertility (diagnosis and treatment of the underlying medical cause)	80% after deductible	80% after deductible
Lab, X-rays and office visits related to family planning	80% after deductible	80% after deductible
Sterilization	80% after deductible	80% after deductible
Abortions	80% after deductible	80% after deductible
Services that are subject to the \$10,000 infertility lifetime maximum		
Artificial insemination	80% after deductible	80% after deductible
In vitro fertilization/GIFT/ ZIFT/ovum transplants	80% after deductible	80% after deductible
Charges associated with cryopreservation or storage of cryopreserved embryos and sperm	80% after deductible	80% after deductible
Exclusions and Limitations		
Reversal of sterilization	Not covered	Not covered
Purchase of donor sperm and any charges for the storage of sperm	Not covered	Not covered
Purchase of donor eggs and any charges associated with the care of the donor required for donor egg retrievals or transfers or gestational carriers	Not covered	Not covered

Non-network plan summaries				
Type of service or supply	Blue Cross Blue Shield Out-of-Area Indemnity Plan		Blue Cross Blue Shield High Deductible Plan	
Mental health/chemical dependency — Coverage provided through CIGNA Behavioral Health				
	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient	100% after \$250 deductible; up to 90 days per calendar year	60% of R&C; up to 30 days per calendar year	100% after \$250 deductible; up to 90 days per calendar year	60% of R&C; up to 30 days per calendar year
Outpatient	100% after \$15 copay per visit; up to 90 visits per calendar year	60% of R&C; up to 30 visits per calendar year	100% after \$15 copay per visit; up to 90 visits per calendar year	60% of R&C; up to 30 visits per calendar year

¹ Separate calendar year deductible may apply for behavioral health services.

² **Premera Blue Cross Foundation EPO members:** See Figure 3.1.1 for exception

³ **Blue Cross Blue Shield Florida BlueCare HMO members** and **Premera Blue Cross Foundation EPO members:** See Figure 3.1.1 for exceptions

⁴ **Premera Blue Cross Foundation EPO members:** See Figure 3.1.1. for exception

⁵ **Independent Health EPO members:** See Figure 3.1.1 for exception

⁶ **Blue Cross Blue Shield Florida BlueCare HMO members:** See Figure 3.1.1 for exception

⁷ **Blue Cross Blue Shield Florida BlueCare HMO members, Companion HMO South Carolina members** and **Independent Health EPO members:** See Figure 3.1.1 for exceptions

⁸ **Blue Cross Blue Shield Florida BlueCare HMO members** and **Harvard Pilgrim HMO members:** See Figure 3.1.1 for exceptions

⁹ **Harvard Pilgrim HMO members:** See Figure 3.1.1 for exception

¹⁰ **Companion HMO South Carolina members, Optima Health HMO Virginia members, Presbyterian EPO (NM) members, Premera Blue Cross Foundation EPO members** and **Blue Cross Blue Shield Florida BlueCare HMO members:** See Figure 3.1.1 for exceptions

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Provisions and definitions for the medical plans listed in Figure 3.0

- Case management is a voluntary program available to patients when a medical case is complicated, when a case involves multiple providers or when intervention by a case manager could improve the outcome for the patient. If the situation meets case management guidelines, the case is assigned an individual case manager. The case management program is designed to provide a process in collaboration with the patient, family, caregiver, physicians and other health care providers. This process focuses on patient education, advocacy and empowerment. The case management program strives to enhance the patient's quality of life, afford continuity of care, facilitate provision of services in the appropriate setting and manage costs and resource allocation to promote high-quality, cost-effective outcomes. Case management plans are based on clinical necessity and attending physicians' orders. As the patient's condition progresses or regresses, the case management plan is modified accordingly. It is important to determine that the patient's needs are being met satisfactorily at all levels, as the patient bridges different resources and moves through the continuum of care. Once a case manager is assigned to a patient, care is coordinated and monitored through that case manager. In limited circumstances under guidelines established by the medical plan claims administrator, a participant receiving case management services may be eligible for benefit substitution at the sole discretion of the health plan. The services must meet all required medical necessity criteria.
- Coinsurance is the percentage of your covered medical expenses you must pay after you have met the deductible. Coinsurance applies only to certain benefits under the PPO and non-network plans.

- Copayment is the fee that must be paid by a plan participant to a provider at the time of service for certain covered expenses and benefits, as described in **Figure 3.1** earlier in this chapter.

Copayments apply to the HMO/EPO and PPO plans, along with certain services under the non-network plans.

- Cosmetic surgery includes any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function; correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or correct or naturally improve a physiological function.
- Custodial services include any services or supplies, including room and board, that are furnished mainly to assist the enrolled family member in personal hygiene, and other activities of daily living (defined below) rather than to provide therapeutic treatment. Care meeting the above criteria is not covered regardless of: who recommends, provides, prescribes or directs the care; where, or by whom, the care is provided; or whether or not the enrolled family member can be (or is being) trained in self care.

Activities of daily living (ADL) include, but are not limited to, such things as bathing, mobility, dressing, toileting, feeding and giving oral medication. These activities can safely and adequately be provided by persons without the technical skills of a covered health care provider (for example, physicians, registered nurses).

- Deductible is a portion of covered medical expenses, not covered by a copayment, that you pay before the plan starts to pay any benefits.
- You must meet a new deductible each calendar year for each available option.
- Expenses in one year do not carry over into the next year. The deductible does

not apply to copayments for office visits or prescription drugs, expenses above reasonable and customary, or noncovered expenses (including the expenses not covered because of failure to precertify a treatment or procedure).

- If you also have coverage for your dependents, a *maximum family deductible* will apply. Any combination of covered expenses of any family members can make up the remainder of the family deductible.
- Detoxification is the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug-dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.
- Doctor or physician refers to any licensed doctor of medicine or osteopathy under the Bank of America medical plans. Benefits for services of other health care professionals are provided only when the services are rendered within the scope of the provider's license, and only to the extent these services are eligible benefits under a Bank of America medical plan.
- Domiciliary care is provided in a hospital or other licensed facility because care in the patient's home is not available or is unsuitable. Hospice care that is certified by the medical plan claims administrator is not considered domiciliary care.
- Duplicate coverage occurs when an associate and/or family members are covered by more than one group plan. If, for instance, a husband and wife both receive insurance coverage through their employers, their family may be covered by more than one group plan. This kind of duplication can result in two plans covering the same expenses.

In cases of duplicate coverage, the *primary plan* pays a benefit first. If your spouse or domestic partner and dependent children are covered under a Bank of America medical plan and also by a group plan of the spouse or domestic partner's employer, specific rules determine which plan pays benefits first.

The Bank of America medical plan is considered your primary plan. The group plan of your spouse or domestic partner is considered his or her primary plan and is considered your secondary plan. If your spouse or domestic partner's plan follows the same rules, the Bank of America medical plan pays first when the covered expense is for services provided to you, the Bank of America associate.

If your children are covered by both your plan and your spouse's or domestic partner's plan, benefits for enrolled dependents are paid first by the Bank of America plan if:

- Your covered children have eligible expenses and your birthday falls earlier in the calendar year than your spouse's or domestic partner's birthday.
- Your covered children have eligible expenses and you and your spouse or domestic partner have the same birthday, but you have had Bank of America coverage longer than your spouse or domestic partner has had his or her coverage.

If your spouse's or domestic partner's medical plan does not have these same rules, your spouse's or domestic partner's plan will determine the order of payment for that plan.

Benefits for children of divorced or separated parents are paid in this order:

- If a court decree states that one parent is responsible for paying medical expenses for the child, the court decree is followed.

- The medical plan of the parent with custody of the child pays first.
- If the parent with custody has remarried, the plan of the new spouse pays second.
- The medical plan of the parent who does not have custody pays last.

When the Bank of America medical plan is not the primary plan, benefits are calculated as if they would be paid under the Bank of America medical plan when no other coverage exists. If the amount to be reimbursed by the Bank of America medical plan would be more than that under the primary plan, the Bank of America plan pays the difference between the two plans. However, if the Bank of America medical plan would pay less than or the same amount as the primary plan, then the Bank of America medical plan pays nothing. This rule is called *maintenance of benefits* or *nonduplication of benefits*.

Example: You have a medical bill for \$200 and the primary medical plan pays 80% or \$160 for the service provided. The Bank of America medical plan is the secondary plan and would also have paid 80% of the service provided. The Bank of America plan will pay nothing because the benefits are the same in both plans and will not be duplicated. But if the Bank of America plan paid 100% coverage (depending on the plan's reasonable and customary allowance for the service provided), then it would pay the remaining 20% or \$40.

- *Durable medical equipment* is equipment determined to be:
 - Designed and able to withstand repeated use
 - Not disposable
 - Made for and used primarily in the treatment of a disease or injury, or its symptoms
 - Generally not useful in the absence of an illness or injury, or its symptoms

- Suitable for use while patient is not confined in a hospital
- Not for use in altering air quality or temperature, and
- Not for exercise or training.
- *Emergency medical condition* is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
 - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
 - Serious impairment to bodily function
 - Serious dysfunction of a bodily organ or part.
- *Experimental or investigational* refers to services or supplies that are determined by your health plan to be experimental. A drug, device, procedure or treatment will be determined to be experimental if any of the following is true:
 - There are not sufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
 - Required FDA approval has not been granted for marketing.
 - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes.
 - The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes.

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- It is not of proven benefit for the specific diagnosis or treatment of your particular condition.
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition.
- It is provided or performed in special settings for research purposes.
- *Formularies* are lists of prescription drugs that the medical plan has determined meet standards of effectiveness and are also cost effective. Medical plans that use formularies may not cover prescription drugs not included in the formulary.
- *Home health services* are those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by your health plan.
- *Hospice care* is a program provided by a hospital, skilled nursing facility or duly licensed care agency; approved by your health plan; and focused on palliative rather than curative treatment for a plan participant who has a medical condition and a prognosis of less than six months to live.
- *Hospital* is an institution, operated as required by law, that meets both of the following:
 - Is primarily engaged in providing health services on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of physicians.
 - Has 24 hour nursing services.



A hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

- *Lifetime maximum* benefit is the total amount of money your health plan will pay towards claims in your lifetime. The Bank of America medical plans described in this handbook do not have lifetime maximum benefits for each covered individual. However, the Bank of America medical plans limit the benefits payable for some types of treatment. Please refer to the **Figures 3.1 and 3.2** for more information about these limits. These include:
 - Inpatient and outpatient treatment for mental health and substance abuse care
 - Physical, occupational and speech therapy
 - Preventive care
 - Home health care
 - Muscular-skeletal manipulation
 - Infertility
 - Travel and lodging in conjunction with transplants.
- *Maintenance care* is furnished primarily to provide room and board (which may include nursing care, training in personal hygiene or other forms of self care or supervisory care by a physician) or care furnished to a person who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment. Maintenance care is intended to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care or when, despite such treatment, there is not a reasonable likelihood that the disability will be reduced.
- The term *medically necessary* or *medical necessity* refers to those services or supplies provided by a hospital, physician, practitioner or other provider that are determined by the medical plan claims administrator to be:
 - Consistent with broadly accepted medical standards in the United States as essential to the evaluation and

treatment of disease or injury and professionally recognized as effective, appropriate and essential based on recognized standards of the health care specialty

- Not furnished primarily for the convenience of the patient, the attending physician or other provider
- Furnished at the most appropriate level that can be provided safely and effectively to the patient
- Likely to produce a significant positive outcome, and no more likely to produce a negative outcome than any alternative service or supplies, as it relates to both the disease or injury involved and your overall health condition.

For hospital inpatient expenses, *medically necessary* refers only to those services and supplies that:

- Satisfy the above requirements
- Require the acute bed-patient (overnight) setting
- Could not have been provided in a physician's office, the outpatient department of a hospital or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

Inpatient services or supplies that are not *medically necessary* include but are not limited to:

- Hospitalization for diagnostic studies that could have been provided on an outpatient basis
- Hospitalization for medical observation or evaluation
- Hospitalization to remove the patient from his/her customary work or home environment for personal comfort
- Hospitalization in a pain management center to treat or cure chronic pain
- Hospitalization in an eating disorder unit to treat eating disorders
- Services or supplies that do not require the technical skills of a medical, mental health or dental professional
- Custodial care, supportive care or rest cures

- Experimental or unproven services and supplies, as determined by your health plan.

The medical plan claims administrator reserves the right to review all claims to determine whether the services or supplies are medically necessary.

- **Mental or nervous condition** refers to a condition that manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited, to psychosis, affective disorders, anxiety disorders, personality disorders, obsessive-compulsive disorders, attention disorders with or without hyperactivity, and other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma or a physical or medical condition.
- **Negotiated charge** is the maximum charge a participating provider has agreed to make for any service or supply for benefits under the PPO, HMO and EPO plans.
- The **out-of-pocket maximum** feature of the PPO and non-network plans puts a cap on the total yearly amount that you have to pay out of your own pocket, including the deductible. After you have paid this out-of-pocket maximum, the plan pays 100% of the reasonable and customary costs for covered medical care. The out-of-pocket maximum does not include:
 - Copayments (including, but not limited to: office visits, preventive care, mental health, chemical dependency services and prescription drugs)

- Coinsurance for prescription drugs received at a nonparticipating pharmacy
- The difference between the generic and brand name cost, when a generic drug is available but you request a brand name drug
- Expenses above reasonable and customary
- Preadmission certification penalties
- Mental health/chemical dependency services.

Refer to **Figures 3.1 and 3.2** for comparisons of out-of-pocket maximums, since maximum benefits for certain types of treatment may be limited.

The out-of-pocket maximum, which includes deductible and coinsurance, satisfied for in-network services can be applied toward the out-of-pocket maximum for out-of-network services and vice versa.

- A **participating provider** generally is a physician, hospital, laboratory or facility that has agreed to participate in your health plan's network of providers and accept the negotiated rates and applicable deductibles, copayments and coinsurances as payment in full for services rendered.
- **Preadmission certification (PAC) and continued-stay review (CSR)** refer to the process used to certify the medical necessity and length of any hospital confinement as a registered bed patient. The medical plan claims administrator performs PAC and CSR through its medical operations programs. PAC will be requested by your physician if you use an HMO/EPO provider and in most cases when you use a PPO participating provider. It is your responsibility to ensure that your provider performs PAC for your hospital confinement. If you are not using an HMO/EPO or PPO participating provider, you must request PAC for each hospital admission. If the admission is a non-urgent admission, you must certify your

confinement time by calling the number shown on your ID card. CSR should be requested prior to the end of the certified length of stay for continued inpatient hospital confinement. Again, if you use an HMO/EPO participating provider and in most cases when you use a PPO participating provider, the provider will take care of the CSR for you. It is your responsibility to ensure that your provider performs the CSR for your hospital confinement. If you are not using an HMO/EPO or PPO participating provider, you must request CSR for each inpatient hospital admission.

Expenses incurred for which benefits would otherwise be paid by the plan do not include the first \$500 of hospital charges made for each separate admission to the hospital as a registered bed patient unless PAC is received before the date of admission or, in an emergency admission, the grace period is within 48 hours, which would translate as the "second scheduled work day" after the date of admission.¹¹

All charges, including those made during any hospital confinement as a registered bed patient for which PAC or CSR was performed that are not certified as medically necessary by the medical plan claims administrator, will not be paid and you will be responsible for those charges.

The deductible or out-of-pocket maximum does not apply to:

- Any charges that are determined not to be medically necessary
- Charges for days in excess of the number of days certified
- The \$500 penalty for failure to obtain PAC or CSR.

¹¹ Aetna plans extend this period to 72 hours if confinement starts on a Friday or Saturday.

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The patient initiates the PAC process by calling the medical plan claims administrator before an elective admission or, in an emergency admission, within the 48-hour grace period, which would translate as the “second scheduled work day” after the date of admission. For an admission because of pregnancy, the medical plan claims administrator should be contacted by the end of the third month of the pregnancy.

The medical plan claims administrator will continue to monitor the confinement until the patient is discharged from the hospital. The results of the review will be communicated to the patient and the attending physician. If you are in a PPO plan and using in-network benefits (participating physicians and hospitals), your provider handles the PAC and CSR for you in most cases. It is your responsibility to ensure that your provider performs CSR for your hospital confinement.

- **Reasonable and customary (R&C) fees** are those set each year by the medical plan claims administrators as the fees that most doctors in a geographic area charge for particular services or procedures. If your doctor charges more, the PPO plans will not pay for the amount in excess of the R&C level. You are responsible for paying this difference if you are not using a PPO participating physician.

HMO/EPO and PPO physicians have agreed to accept negotiated fees. If you enrolled in an HMO/EPO, no benefits are paid if you use an out-of-network provider (except for emergency or urgent care). If you are enrolled in a PPO and are not using a PPO physician or are enrolled in a non-network plan option, it is a good idea to ask your doctor, in advance, the fee he or she charges for a procedure. You should call your medical plan claims administrator to find out if that fee is within the R&C

level. You will be asked the ZIP code of the provider when you call.

When covered health services are received from out-of-network providers, the medical plan claims administrator calculates R&C based on available data resources of competitive fees in that geographic area. In this case, R&C is the fee(s) that is negotiated with the out-of-network provider.

You or your physician also can request a predetermination of benefits from the medical plan claims administrator. If you discuss fees in advance, some doctors are willing to accept R&C as full payment. Any amount that you are charged in excess of the R&C is shown on the explanation of benefits (EOB) that you receive from the medical plan claims administrator. Remember, you are responsible for paying this amount.

- A *skilled nursing facility* qualifies for coverage when the facility is accepted by Medicare or when the facility:
 - Is licensed to provide inpatient skilled nursing and physical restoration services
 - Is under the supervision of a physician or registered nurse and provides 24-hour patient care by a staff of licensed nurses, directed by a full-time registered nurse
 - Has an active use-review plan for all patients
 - Is not a place for rest, the aged, alcohol/substance abuse patients, custodial or education care, care of mental health disorders or mental retardation.
- *Unproven* refers to a drug, device, procedure or treatment that is not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and are not based on trials that meet either of the following designs:
 - Well-conducted randomized controlled trials (two or more treatments are compared to each

other, and the patient is not allowed to choose which treatment is received)

- Well-conducted cohort studies (patients who receive study treatment are compared to a group of patients who receive standard therapy; the comparison group must be nearly identical to the study treatment group).

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described above.

Covered services of the medical plans listed in Figure 3.0

Unless otherwise noted in **Figure 3.1**, these plans cover medically necessary care for the following services and supplies:

Primary and preventive care

Preventive care is covered on an in-network basis in the HMO/EPO plans. It is covered on an in- and out-of-network basis in the PPO plans. Preventive care is also covered in the Blue Cross Blue Shield Out-of-Area Indemnity and High Deductible Plan.

Primary and preventive care includes:

- Routine office visits
- Office surgery performed in a physician's office (copayment amount dependent on provider)
- Examinations and immunizations for well-child care at intervals according to health plan schedule
- Preventive physical exams for covered individuals (for more specific information, please contact your plan's member services number)
- Adolescent immunizations
- Adult preventive immunizations
- Annual well-woman examinations (office visits)
- Preventive mammograms
- Preventive lab tests and X-rays

- Health education counseling and information.

Specialty and outpatient care

The plans cover the following specialty and outpatient services:

- Outpatient surgery for a covered surgical procedure, including outpatient hospital facilities, such as freestanding ambulatory facilities, a doctor's office, a short-stay surgical unit or outpatient unit or an emergency room of a hospital (for the HMO/EPO plans, outpatient surgery is covered only when furnished by a participating outpatient surgery center)
- Pre-operative and post-operative care
- Casts and dressings
- Radiation therapy
- Cancer chemotherapy
- Short-term cardiac rehabilitation provided on an outpatient basis when medically necessary
- Diagnostic, laboratory and X-ray services
- Pain management and symptom control
- Oral surgery that is medical in nature (for example, limited treatment of bone fractures, and removal of tumors and orthodontogenic cysts)
- Allergy testing and treatment injections, including preventive allergy desensitization injections (please refer to **Figures 3.1** and **3.2** for clarification of the payment schedule)
- Chiropractic services (muscular skeletal manipulation) with maximum shown in Figures **3.1** and **3.2**
- TMJ services
- Diagnostic mammograms based on standard medical practice
- Skilled nursing facilities
- Durable medical equipment: includes wheelchairs, hospital beds, delivery pumps for tube feedings (including tubing and connectors), braces that stabilize an injured body part including necessary adjustments to shoes to accommodate braces, oxygen concentrator units and the purchase or rental of equipment to administer oxygen, mechanical equipment necessary for the treatment of chronic

or acute respiratory failure or condition, and other items that the medical plan claims administrator determines are durable medical equipment. In lieu of rental of durable medical equipment, the following may be covered:

- The initial purchase of a single unit of equipment if it is shown that long-term care is planned and that such equipment either cannot be rented or is likely to cost less to purchase than to rent. The medical plan claims administrator will determine if the equipment should be purchased or rented. If more than one piece of durable medical equipment can meet the functional need, benefits are payable only for the most cost-effective piece of equipment.
- Blood glucose testing monitors are provided free of charge through Caremark (one per year) after copay, and may also be provided through your medical plan. Please contact Caremark or your medical plan for further details.
- External prosthetic devices: charges for initial purchase and fitting of external prosthetic devices used as a replacement or substitute for missing body parts and necessary to alleviate or correct sickness, injury or congenital defect, including artificial arms, legs and terminal devices such as a hand or hook, eyes, and breast prostheses. Wigs are covered when related to hair loss for a serious medical condition. (Replacement of such prostheses must be authorized by the medical plan claims administrator and is covered only if needed because of normal body growth, physical changes that render the device ineffective or excessive wear.) If more than one prosthetic device can meet the functional need, benefits are payable only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of, a physician. Benefits are provided for a single purchase, including repairs, of a type of prosthetic device.
- Home health care benefits, limited as shown in **Figures 3.1** and **3.2**. Each visit by an employee of a home health care agency will be considered one home health care visit, and each four hours of home health aide services will be considered one home health care visit. Home health care services include intermittent visits by professional nurses and other professionals for members who do not require confinement in a hospital or skilled nursing facility but who:
 - Require skilled care
 - Are housebound because of disabling conditions
 - Are unable to receive medical care on an ambulatory outpatient basis and do not require extended daily attention by a professional nurse.
- Skilled nursing facility care:
 - When you are convalescing from an illness or injury, your physician may recommend that you receive treatment in a skilled nursing facility. This stay in a skilled nursing facility must be preapproved by a medical plan medical consultant and is limited to the maximum shown in **Figures 3.1** and **3.2**.

The annual maximum does not apply to services provided for home infusion therapy, defined as services provided by an approved home infusion company only when services are medically necessary and ordered by an attending physician. Home infusion services include the pharmaceutical when administered intravenously, medical supplies and any nursing services required to support the infusion. Nursing services include the administration of intravenous medication, if medically necessary, and any lab tests, dressing changes and intravenous line care. Home health care does not include those services considered to be custodial.

- Skilled nursing facility care:
 - When you are convalescing from an illness or injury, your physician may recommend that you receive treatment in a skilled nursing facility. This stay in a skilled nursing facility must be preapproved by a medical plan medical consultant and is limited to the maximum shown in **Figures 3.1** and **3.2**.

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- A skilled nursing facility qualifies for coverage under the Bank of America medical plan when the facility is accepted by Medicare or when the facility:
 - Is licensed to provide inpatient skilled nursing and physical restoration services
 - Is under the supervision of a physician or registered nurse and provides 24-hour patient care by a staff of licensed nurses under the direction of a full-time registered nurse
 - Has an active use-review plan for all patients
 - Is not a place for rest, the aged, alcohol/substance abuse patients, custodial or educational care or care of mental health disorders or mental retardation.

Nursing services and restorative services must be received by the patient, and the care received must be expected to improve the patient's condition and facilitate discharge from the skilled nursing facility.

- Hospice care: includes charges incurred because of terminal illness; the following hospice care services provided under a hospice care program are included:
 - Bed and board, services and supplies, except for any stay of confinement in a private room
 - Hospice facility services provided on an outpatient basis
 - Professional services provided by a physician
 - Individual and family counseling by a psychologist, social worker, family counselor or ordained minister, including short-term bereavement counseling sessions
 - Pain relief treatment, including drugs, medicines and medical supplies
 - Home health care agency services for:
 - Part-time or intermittent nursing care by, or supervised by, a nurse
 - Part-time or intermittent services by a home health aide

- Physical, occupational and speech therapy
- Medical supplies, drugs and medicines lawfully dispensed only on the written prescription of a physician
- Laboratory services, but only to the extent such charges would have been payable if the person had remained or been confined in a hospital or hospice facility.
- The following charges for hospice care services are not included as covered expenses:
 - Services provided by a person who is a member of your family or your dependent's family, or who normally resides in your house or your dependent's house
 - Any period when you or your dependent is not in the care of a physician
 - Any services or supplies not listed in the hospice care program
 - Any curative or life-prolonging procedures
 - Services or supplies that are primarily to aid you or your dependent in daily living.
- X-rays and lab tests: prescribed for a specific illness or injury and preventive care
- Occupational therapy: provided only for purposes of training a plan participant to perform the activities of daily living; coverage is available only for rehabilitation following injuries, surgery or acute medical conditions, such as a stroke; services provided on an outpatient basis are limited as described in **Figures 3.1 and 3.2**
- Physical therapy: subject to review for medical necessity and limited as described in **Figures 3.1 and 3.2**
- Speech therapy: subject to medical necessity, doctor-prescribed services of a speech therapist for an illness or injury for rehabilitation purposes only; the illness or injury must occur to a person while covered by the plan, and the person must have had normal speech before the illness or injury;

congenital or developmental speech therapy is covered through age 6; coverage is limited as described in **Figures 3.1 and 3.2**.

Prescription drug benefits

Unless otherwise noted in **Figure 3.1**, Caremark provides drug benefits for participants enrolled in the medical plans listed in **Figure 3.0**. Caremark is a manager of prescription drug programs with a large network of participating pharmacies.

If you or any of your eligible dependents, while insured for prescription drug benefits, incur expenses for charges made by a pharmacy for covered prescription drugs for an injury or a sickness, the plan pays that portion of the expense remaining after you or your dependent has paid the required copayment.

No other part of the plan will pay benefits for expenses that are payable under the prescription drug benefit.

The term *covered prescription drug* means:

- A federal legend drug for which a written prescription is required
- A compound medication of which at least one ingredient is a federal legend drug
- Insulin dispensed only with the written prescription of a physician
- Diabetic supplies: needles and syringes, alcohol swabs, blood glucose testing strips, blood glucose testing monitors (one per year), urine testing strips/tabs, lancets (excluding administration devices)
- Tretinoin for individuals who satisfy certain criteria and for whom the treatment is not for cosmetic therapy
- Contraceptives
- Infertility drugs
- Any other drug that, by applicable state law, may be dispensed only with the written prescription of a physician.

Check with Caremark if you are not sure whether a certain prescription medicine is covered under your plan. You can also go to www.caremark.com/bankofamerica for more information.

Inpatient services

The following services are covered under the medical plans:

- Room and board up to the hospital's charge for a semiprivate room, including all meals and dietary services, general nursing care, drugs and oxygen, blood and plasma, X-rays and laboratory tests
- Hospital special care units
- Operating rooms, anesthetic supplies furnished by the hospital and surgical supplies, dressings and cast materials
- Physician charges
- X-rays and lab tests
- Hospice facilities
- Special care units
- Rehabilitation services
- Skilled nursing facility care

Surgical benefits

The following services are covered under the medical plan:

- Surgical benefits cover surgery performed to treat an illness or injury; medical services by surgeons (MDs or DOs), assistant surgeons, anesthesiologists, consultants (during and after an operation and any required second opinions); and medical services of podiatrists.
- When multiple surgical procedures are performed during the same operative session, benefits for the secondary procedure(s) will be determined based on the medical policy of the medical plan claims administrator. No separate payment will be provided for procedures that are incidental to or an integral part of the primary procedure.
- Surgical services include:
 - A cutting procedure (except for cutting procedures of the mouth that are considered dental expenses in the dental plan)

- Suturing
- Treatment of a broken bone or dislocation
- Radiotherapy used to remove a tumor, instead of a cutting procedure
- Electrocauterization
- Laser surgery
- Injection treatment for hemorrhoids and thrombosed veins
- Endoscopic procedures
- Preoperative and postoperative care
- Blood and blood products, including plasma.
- Limited surgical procedures:
 - Circumcision is covered only for a newborn child.
 - Gastric bypass surgery is only covered with a network provider.
 - Jaw alignment surgery is covered only if the surgery is medically necessary to correct a birth defect, injury or arthritic condition and the surgery does not involve teeth and gums.
 - Surgical correction of congenital defects may be covered if the birth defect impedes a natural body function. The procedure must be preapproved by the medical plan claims administrator.
- Reconstructive surgery is considered a covered expense if the surgery:
 - Is to correct deformities from an injury that resulted in bodily damage requiring the surgery
 - Is performed on a person following surgery and both the surgery and the reconstructive surgery are essential and medically necessary
 - Is performed on any one of your covered dependents who has not reached skeletal maturity
 - Reconstructive breast surgery is covered following a mastectomy, including reconstruction of the breast on which the mastectomy is performed, including aerolar reconstruction and the insertion of a breast implant, surgery and reconstruction performed on the nondiseased breast to establish symmetry when reconstructive breast surgery on the diseased

breast has been performed, and medically necessary physical therapy to treat the complications of the mastectomy, including lymphedema.

- Temporomandibular joint syndrome surgery is covered only if it is medically necessary and other nonsurgical methods have been unsuccessful. Physical therapy and injections in a provider's office will be covered and subject to physical therapy limits described in **Figures 3.1** and **3.2**.

- Organ transplants that are not experimental or investigational, and that are considered accepted medical practice are covered, including the cost of donor organs, if the recipient of the transplant is enrolled in the plan.

Charges for searches through a recognized donor registry for acceptable donors are also covered. Cornea transplants are covered. If you have prior authorization from the medical plan claims administrator, human heart transplants, human lung transplants, human heart and lung transplants, human liver transplants, human small bowel transplants, human liver and small bowel transplants, human kidney transplants, human pancreas transplants, human kidney and pancreas transplants, peripheral stem cell transplants and bone marrow transplants (with or without high-dose chemotherapy) are covered. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. (In the HMO/EPO plans, all transplants must be ordered by your PCP and participating specialist, and approved in advance by your health plan. Transplants must be performed in hospitals specifically approved and designated by your health plan to perform the procedure.)

Health and wellness

Health care benefits

The term *recipient* is defined to include you or your covered dependent who receives preapproved transplant-related services during evaluation, candidacy, transplant event or post-transplant care.

If you or your dependent elects to use an organ transplant network facility, and treatment and the network facility have been preapproved by the medical plan claims administrator, travel expenses for the person receiving the transplant include charges for:

- Transportation to and from the transplant site, or other preapproved medical facility, of the patient and one companion who is traveling on the same day(s)
- Lodging, while at or traveling to and from the transplant site, for the patient (while not confined) and one companion at \$50 per day for one person or up to \$100 for two people
- A combined lifetime maximum of \$10,000 per covered person per episode of care for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this plan in connection with all transplant procedures.

These transportation and lodging charges are considered travel expenses for one companion at any time in addition to the actual transplant recipient. If the transplant recipient is a minor, these travel expenses can be considered for both parents. The term companion includes a spouse, family member, domestic partner, legal guardian of you or your enrolled dependent or any unrelated person actively involved as a caregiver.

Travel expenses do not include any charges for:

- Transportation, lodging and food associated with an organ transplant

performed at a facility other than the organ transplant network facility affiliated with the health plan

- Transplant travel benefit costs incurred because of travel within 100 miles (for Aetna), and within 50 miles (for Blue Cross Blue Shield) from your home
- Food while at or traveling to and from the transplant site
- Air ambulance travel
- Laundry bills
- Telephone bills
- Alcohol or tobacco products
- Transportation charges that exceed coach-class rates.

Organ transplant travel benefits may be considered taxable income by the Internal Revenue Service. Please consult with a tax advisor for more information.¹²

Emergency care

If you need emergency care, you are covered 24 hours a day, seven days a week, anywhere in the world.

Some examples of emergencies are:

- Heart attack or suspected heart attack
- Suspected overdose of medication
- Poisoning
- Severe burns
- Severe shortness of breath
- High fever (especially in infants)
- Uncontrolled or severe bleeding
- Loss of consciousness.

Whether you are in or out of the health plan's service area, follow the guidelines below when you believe you may need emergency care:

1. Call your preferred provider or PCP first, if possible. Your preferred provider or PCP is required to provide emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility or dial 911 (if your area has this

emergency response service).

2. After assessing and stabilizing your condition, the emergency facility should contact your preferred provider or PCP so he or she can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP (under certain HMO/EPO plans) or the medical plan claims administrator (under the HMO/EPO and PPO plans) within 48 hours. The emergency room copayment will be waived if you are admitted to the hospital.

Follow-up care after emergencies

All follow-up care should be coordinated by your preferred provider or PCP. Contact your medical plan for any prior authorization requirements.

Urgent care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit.
- You could not reasonably have anticipated the need for the care prior to leaving the network service area.
- and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Some examples of urgent medical conditions are severe vomiting, severe earaches, severe sore throat and high fever.

Follow-up care provided by your preferred provider or PCP is fully covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a prior referral from your PCP (if you are required to select a PCP).

¹² **Harvard Pilgrim HMO members:** Travel expenses for organ transplants as described are not covered by Harvard Pilgrim. Members can contact Harvard Pilgrim directly for coverage information specific to organ transplants.

Maternity care

Midwives

The Aetna and Blue Cross Blue Shield EPO, PPO and non-network (indemnity) plans cover charges for deliveries by certified nurse midwives and obstetrical delivery services provided in licensed birthing centers, or in physician offices. If you participate in a regional HMO/EPO, contact your plan for information on how these services are covered.

Prenatal care/Maternity care

- The medical plan claims administrator should be notified as soon as pregnancy is confirmed, and, if possible, no later than the end of the first trimester. Early notification is especially important if a woman has been identified as a candidate for a high-risk pregnancy. The medical plan claims administrator can help you assess risk factors and assist during the pregnancy. In addition, the medical plan claims administrator should be notified at the time of delivery. Except as provided below, all plan benefits are available for pregnancy and complications of pregnancy, including prenatal and post-delivery care, as well as prenatal vitamins when prescribed by the physician.
- Procedures to diagnose or treat the condition of a fetus prior to birth are not covered, except when medically necessary for:
 - Amniocentesis and/or chromosomal analysis
 - Fetal monitoring
 - Pregnancy-related ultrasounds
 - Alpha fetoprotein
 - Chorionic villus biopsy
- Coverage for inpatient care connected with childbirth is at least 48 hours following a normal vaginal delivery and at least 96 hours following a Caesarean section. However, the stay may be shorter with the mother's and physician's consent. In this case, a

health care provider may be sent for two home visits. If the hospital stay exceeds these periods, the hospital and surgical use review programs apply.

The medical plan claims administrator can provide support to expectant mothers, to make wise choices that achieve the healthiest outcomes. Call the medical plan claims administrator for:

- Information at different stages of pregnancy
- A pregnancy assessment to determine special needs
- Postpartum support and information.

Preventive newborn care expenses (nursery charges)

Expenses for the birth and delivery of a baby are covered as part of the mother's expenses. All future expenses related to the baby's care that appear on a bill under the baby's name are the baby's expenses, handled separately and subject to the baby's deductible.

Well-newborn care expenses

The plan covers preventive nursery charges along with miscellaneous charges (for example, lab work, X-rays, pharmacy and supplies) and preventive pediatrician visits during the baby's initial confinement. For coverage of future preventive expenses, see "Preventive care" earlier in this section.

Sick-newborn care expenses

If the baby has to remain in the hospital longer than the mother, the baby's extended stay must be precertified by the medical plan claims administrator. If the extended stay is not precertified but is medically necessary, under the PPO plan there will be a \$500 penalty if participating providers are not used. Also, if the extended stay is not precertified, coverage for any days determined not medically necessary will

be denied. The grace period to notify for emergency admission or extended stay is within 48 hours, which translates to the "second scheduled work day" after the date of admission.

Under the HMO/EPO plans, you must ensure that you or your participating obstetrician obtains precertification from your health plan for all obstetrical care after your first visit. This requirement also applies to any tests performed outside of his or her office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services, including the baby's extended stay if deemed necessary by your physician; otherwise coverage for any days determined not medically necessary will be denied.¹³

Family planning

Infertility treatment

Most procedures associated with the treatment of dysfunction involving infertility and sterility are covered by the plan. There is a \$10,000 lifetime maximum for medical care for certain infertility services provided on and after January 1, 2004 and a separate \$10,000 lifetime maximum for prescription drugs to treat infertility on and after January 1, 2004, under all the medical plans listed in **Figure 3.0** combined. Please refer to **Figures 3.1** and **3.2** for limitations.

Sterilization

Tubal ligations (performed during normal delivery or as separate procedures) and vasectomies are covered by the plan. Reversal of sterilization is not covered.

Abortions

Abortions are covered.

¹³ **United Healthcare Choice EPO members:** Precertification referrals not required for obstetrical care.

Health and wellness

Health care benefits

Dependent children

If an associate's enrolled dependent child delivers a baby of her own, the charges for the delivery, physician and hospital services are covered. All charges associated with the newborn, including but not limited to nursery charges, are not covered.

Mental health and chemical dependency

If you enroll in a company-sponsored medical plan, you are automatically eligible for mental health/chemical dependency benefits. Most of the bank's medical plans offer this benefit directly through CIGNA Behavioral Health (CBH). This section describes the benefits available through CBH.

Your health plan comparison chart, which was included in your enrollment package, indicates whether your mental health/chemical dependency benefits are provided by CBH or directly through your health plan. You can also check your ID card. Contact information for accessing your mental health/chemical dependency benefits is included on your card.

You may access your mental health/chemical dependency benefits directly by calling member services at the phone number listed on your ID card. They will direct you to a provider or facility appropriate for those problems you or a family member may be experiencing.

Mental health and chemical dependency includes treatment rendered in connection with conditions classified in the *Diagnosis and Statistical Manual of Mental Disorders* (Fourth Edition-Revised) of the American Psychiatric Association. This diagnostic classification represents that which is generally and universally employed by mental health and

chemical dependency clinicians in the United States at this time. Services include, but are not limited to:

- Acute inpatient and partial hospitalization
- Outpatient office visits
- Intensive outpatient programs
- Residential treatment. An approved treatment facility must meet the following criteria:

- Accredited by the Joint Commission on Accreditation of Healthcare Organizations or an appropriate state licensing board
- Provides 24-hour nursing care
- Has an onsite psychiatrist to provide weekly assessments.

Please note: Treatment at licensed halfway houses and group homes is covered under the mental health and chemical dependency program only in conjunction with an intensive outpatient program or some other authorized active treatment

All services must be deemed medically necessary. For all levels of care except routine outpatient care, your treatment must be precertified and approved in advance by CBH. If you have any questions about when precertification approval is required, or would like additional information about covered services, contact CBH at **1.888.734.3453**.

Inpatient

The maximum annual benefit for inpatient care for mental health or chemical dependency, including hospital visits by a doctor, is shown in **Figures 3.1 and 3.2**. The medical plan claims administrator must approve the treatment plan.

For serious inpatient cases identified by the medical plan claims administrator, voluntary case management is available. A case manager is assigned to help coordinate the most appropriate and cost-effective care and to explore all potential options and alternatives for that care.

Outpatient

Outpatient and nonhospital benefit provisions and limitations for mental health or chemical dependency care under each medical plan are described in **Figures 3.1 and 3.2**.

Precertification requirements

Precertification is required prior to receiving the services listed in **Figure 3.2.1**. Associates enrolled in the HMO/EPO plans or those using in-network providers in the PPO plan must have their precertification submitted by their providers. Associates enrolled in the Blue Cross Blue Shield out-of-area plan or the Blue Cross Blue Shield high deductible plan should call Blue Cross Blue Shield directly to ensure they are properly precertified prior to receiving these services. In all cases, it is your responsibility to ensure that precertification has been obtained prior to receiving services.

For routine outpatient mental health and chemical dependency care (whether you receive it in-network or out-of-network), you do not need to precertify with CBH. Precertification is required for all inpatient care, and for all alternatives to inpatient care including residential treatment centers, partial hospitalization and Intensive Outpatient Programs. Failure to call within 48 hours of an admission will result in a \$500 penalty. All coverage is subject to medical necessity.

To precertify, call CBH at **1.888.734.3453**.

Figure 3.2.1

Services for which precertification is required		
Aetna Select EPO Aetna Choice II PPO	Blue Cross Blue Shield Florida BlueCare HMO	Blue Cross Blue Shield EPO, PPO, Out-of-Area and High Deductible Plans
<ul style="list-style-type: none"> Elective non-emergency transportation by ambulance, plane or medical van Injection of filling material Inpatient admission for mental health services Reconstructive repair of pectus excavatum or carinatum Otoplasty Breast reconstruction Lipectomy Excision, excessive skin including lipectomy and abdominoplasty Rhytidectomy Cervicoplasty Chemical peel Blepharoplasty, canthopexy, canthoplasty Breast reduction/ mammoplasty Rhinoplasty Sclerotherapy Venous ligation Gynecomastia surgery Intersex surgery Gastroplasty/gastric bypass (not a covered benefit in the out-of-network component of the PPO plan) Transplants (pre-transplant, evaluation and post-transplant treatment), including: <ul style="list-style-type: none"> Adrenal tissue transplant Bone marrow transplant Heart transplant Heart/lung transplant Islet cell tissue transplant Liver transplant Lung transplant Pancreas transplant Renal transplant Intestinal transplant Multivisceral organs transplant Small intestine and liver transplant Simultaneous pancreas/kidney transplant 	<ul style="list-style-type: none"> Evaluation and surgery for pediatric (age 17 or less) congenital heart disease Oral and maxillofacial surgical procedures (Note: all procedures require medical review no matter where the procedure is performed) Orthognathic surgery procedures and osteotomies Surgical management of TMJ Dental services Oral appliances Uvulopalatopharyngoplasty (UPPP) <p>Durable medical equipment:</p> <ul style="list-style-type: none"> Beds excluding manual and semi-electric Electric scooter Customized braces Upper limb prosthetics Lower limb prosthetics Motorized wheelchair <p>Home health care:</p> <ul style="list-style-type: none"> Nursing care in the home by registered nurse, per hour Nursing care in the home by licensed practical nurse, per hour Home infusion immunotherapy Home infusion chelation therapy All other home health care Maternity management home care Inpatient hospital non-surgical Skilled nursing facilities Hospice Inpatient rehabilitation facility All other inpatient surgical confinements Non-preventive inpatient maternity Requests for in-network benefits for non-participating providers 	<ul style="list-style-type: none"> Annual OB/GYN exam Chiropractic services Gastric bypass surgery Podiatry services Dermatology services — only for the first five visits, visit six will require PCP authorization <p>Blue Cross Blue Shield Florida BlueCare HMO members have open access to the services listed above without PCP referral. The member is held harmless if they utilize services ordered by the PCP or Contracting Specialist and the provider did not obtain the necessary authorizations. A list of the services which require the provider to obtain authorization is available at www.bcbstfl.com.</p> <p>Inpatient services:</p> <ul style="list-style-type: none"> All inpatient admissions, with the exception of normal maternity Subacute inpatient treatment Inpatient rehabilitation confinement Inpatient hospice Skilled nursing facility Hysterectomy — age 35 and under Uterine artery embolization <p>Outpatient services:</p> <ul style="list-style-type: none"> Home health care Hysterectomy — age 35 and under PET scans Uterine artery embolization <p>Other services:</p> <ul style="list-style-type: none"> Dental services Reconstructive procedures All transplantation services

Health and wellness

Health care benefits

Services for which precertification is required		
BlueChoice HMO Georgia	CIGNA Open Access HMO	Companion HMO South Carolina
<p>Inpatient services:</p> <ul style="list-style-type: none"> • All inpatient admissions, with the exception of normal maternity • Sub acute inpatient treatment • Inpatient rehabilitation confinement • Inpatient hospice • Skilled nursing facility • Hysterectomy — age 35 and under • Uterine artery embolization • Inpatient admission for mental health services <p>Outpatient services including observation:</p> <ul style="list-style-type: none"> • Arthroscopy — shoulder and knee • Biofeedback • Cardiac/pulmonary rehabilitation • Colonoscopy • CT Scans • DEXA bone scans • EGD • EMG/nerve • Endometrial ablation • Epidurals for pain management • Gastric obesity surgery • Gastroplasty/gastric bypass (not a covered benefit in the out-of-network component of the PPO plan) • HIDA scans • Home health care • Hysterectomy • Laminectomy • MRI • MUGA • Nasal/sinus endoscopy • Orthognathic/TMJ • PET scans • Septoplasty • Sleep studies • Tilt table evaluation • UPPP • Uterine artery embolization <p>Other services:</p> <ul style="list-style-type: none"> • Accidental dental services • Reconstructive procedures • All transplantation services 	<p>Inpatient admission for mental health services</p> <ul style="list-style-type: none"> • Obesity surgery • Major skin procedures • Face/jaw surgery (except trauma) • Transplants • Breast reduction • Gastric bypass surgery • Hysterectomy (except cancer surgery) • Experimental or investigational • Back/spine (except trauma, malignancy) • Unlisted codes, category III codes • CT • MRI • MRA • PET • UPPP • Occupational therapy • Speech therapy • Nutritional therapy • Biofeedback • Mental health after 6th visit • Acupuncture • Infertility surgery • Penile implants • Cochlear implants • Insulin pumps • Injectables over \$200 • Home health care • Home infusion therapy • Cardiac rehab • Pulmonary rehab • Procedures which are frequently cosmetic (e.g., durable medical equipment over \$250) • Orthotics • External prosthetics • Ostomy supplies • Dental related services • Transplant evaluation or transplant related • Any surgeries on the inpatient prior-authorization list 	<p>Authorizations for services are the responsibility of the PCP or specialist. Once the PCP has referred a member to a specialist, it becomes the specialist's responsibility to obtain authorizations for services or procedures that require authorization.</p> <p>Authorizations can be obtained by calling 1.800.950.5387 or by faxing the <i>Authorization Request for Services Fax Form</i> to 1.800.610.5685.</p> <p>Inpatient services:</p> <ul style="list-style-type: none"> • All hospital admissions (elective and emergency) <p>Outpatient facility services</p> <ul style="list-style-type: none"> • Emergency room (when sent by physician) • Surgical procedures <p>Radiology services (any place of service)—For radiology services, always call 1.800.950.5387 and select option #1</p> <ul style="list-style-type: none"> • CT scans • Dexa/bone density studies—CPT 76075 • MRI and MRA scans • PET scans • Spect scans • Nuclear cardiology studies (including stress thallium) <p>Office-based services (performed in physician office)</p> <ul style="list-style-type: none"> • Echocardiography (including color flow) • EGD • Colonoscopies • Vascular doppler exams/ultrasounds (carotid and non-invasive studies) • Endometrial ablation, any method • Complex pulmonary function tests (except when rendered by pulmonologist or allergist) <p>• Thyroid ultrasounds—CPT 76536 (except when rendered by general surgeon or endocrinologist)</p> <ul style="list-style-type: none"> • Nerve conduction studies/EMG's (except when rendered by neurologist or physiatrist) <p>Other services (any place of service)</p> <ul style="list-style-type: none"> • Biofeedback • Cardiac rehabilitation • Cholesterol subparticle testing • Cosmetic procedures • Diabetic teaching programs (except at approved facilities —call 1.800.327.3183 for list) • Guided imagery—CPT 61795 (except when rendered by neurosurgeons) • Impotence treatment • Infertility treatment • Investigational procedures/services (ESWL) • Neurostimulators (muscle, bone, TENS) • Pain management (injections, multidisciplinary programs epidural steroids, etc.) • Podiatry services • Pregen • Prostate thermotherapy • PT, OT and speech therapies • Refractive surgeries/services • Referrals to non-contracting providers • Sleep studies • Sclerotherapy/all varicose vein procedures including radiofrequency and laser • Spinal manipulation—call 1.800.950.5387 for authorization • Tilt table testing • UPPP

Services for which precertification is required			
Companion HMO South Carolina (continued)	Harvard Pilgrim HMO	Independent Health EPO	MVP Select Care EPO
<p>Laboratory Services Certain lab services require preauthorization. Contact your physician for further information.</p> <p>Durable medical equipment (DME), home health, hospice, orthotics, prosthetics and other medical supplies Call Ancillary Care Management at 1.888 558.5850 to pre-authorize the following:</p> <ul style="list-style-type: none"> • DME & medical supplies over \$100 • Home health and hospice care • Orthotics, prosthetics and shoe inserts 	<ul style="list-style-type: none"> • Assisted reproductive technologies (ART) • Bariatric surgery (including gastric stapling/ gastric bypass) • Blepharoplasty • Breast implant removal • Breast reduction mammoplasty • Miscellaneous DME • Elective out-of-network services including referrals to non-participating providers • Speech therapy (MA only) • Home health care, including home infusion and home hospice • Infant formula • Inpatient admission for mental health services • Inpatient and SDC dental care, extractions and oral or periodontal surgery • Inpatient rehabilitation care including inpatient pulmonary rehabilitation • Inpatient skilled nursing care (SNF) • Intra-facility admissions (transfers) • Laminectomy/fusion/ discectomy • Mandibular/Maxillary osteotomy • New technologies for which Harvard Pilgrim HMO has not yet made a coverage determination • Outpatient enteral nutrition • Outpatient pulmonary rehabilitation • Panniculectomy and removal of excess tissue • Ptosis repair • Rhinoplasty • Septoplasty • Temporomandibular joint (TMJ) treatment • Treatment for varicose veins • Uvulopalatopharyngoplasty (UPPP) 	<ul style="list-style-type: none"> • Accidental dental (after initial exam & X-rays) • Ambulance (for planned transportation, but not for emergency use) • Cardiac rehabilitation (CHF only) • Chiropractic care (after three visits) • Diabetic equipment (e.g., blood glucose monitor, glucowatch) • Diabetic shoes and inserts • Durable medical equipment • Gastric bypass surgery • Home health care/aide (required before the first visit) • Hospice (advance care planning only) • Inpatient admission for mental health services • Inpatient hospital stays (including inpatient medical rehab facilities) • Medical expendable supplies • Occupational therapy (required after initial evaluation) • Surgery that could be deemed cosmetic • Prosthetics and appliances (P&A) • Pulmonary rehab • Skilled nursing facility (at facility) • Speech therapy (required after initial evaluation) • Transplants (required for donors and recipients) 	<ul style="list-style-type: none"> • Inpatient admission for mental health services • Diagnostic laparoscopy • Lumbar laminectomy (discectomy) • Hysterectomy • Septoplasty • Sinus surgery • Spinal fusion • Cataract surgery • Hammer toe surgery • Hemorrhoidectomy • Shoulder arthroscopy • Blepharoplasty • Breast implantation • Breast reduction • Cochlear implant • Oral surgery/orthognathic surgery • Rhinoplasty treatment related to TMJ (temporomandibular joint disorder) • Gastric bypass surgery/ gastroplasty • Purchase of durable medical equipment or prosthetic devices

Health and wellness

Health care benefits

Services for which precertification is required			
Optima Health HMO Virginia	Premera Blue Cross Foundation EPO	Presbyterian EPO New Mexico	
<ul style="list-style-type: none"> Outpatient surgery Outpatient therapy services (physical, occupational, speech) Outpatient rehabilitation services (cardiac, pulmonary and vascular) Outpatient diagnostic services (including X-ray, MRI, MRA, CAT, PET) Outpatient chemo-radiation, IV and respiratory therapy services Outpatient dialysis services Inpatient admission for mental health services Inpatient care coverage Pre- and post-natal OB care Inpatient mental health care Outpatient mental health care Artificial limb services Durable medical equipment (including repair, replacement & duplicates) Early intervention services Home health care Orthopedic and prosthetic appliances (including repair, replacement & duplicates) Skilled nursing facility care Gastric bypass surgery 	<p>No precertification is required.</p>	<ul style="list-style-type: none"> Out-of-plan, out-of-network services (exception: emergent and urgently needed services, including dialysis) Medical/surgical/psychiatric inpatient admissions and observation stays greater than 24 hours Behavioral health services including counseling and inpatient Bone growth stimulator (must use contracted vendor) Detoxification (acute) requiring medical intervention (alcohol or substance abuse) Durable medical equipment purchases above \$1,000 (exception: oxygen, if Medicare guidelines are met) Prosthetic purchases above \$1,000 Foot orthotics (regardless of dollar amount) Drugs provided and administered in the office/outpatient Home uterine monitoring Hospice outpatient Investigational/new tech/experimental services, procedures and drugs (including drugs and procedures for infertility) Clinical cancer trials Oral nutritional supplements PET (Positron Emission Tomography) scans All cosmetic surgery Mastectomy for gynecomastia Obesity surgery and gastric bypass surgery Saphenous Vein Ligation Sclerotherapy Transmyocardial revascularization (TMR) as a sole procedure Intradiscal Electrothermal Therapy (IDET) 	<ul style="list-style-type: none"> Kyphoplasty Meniscal transplants Tattoo removals Collagen and Botox injections Dermabrasion Chemical peel Salabrasion Rhinophyma excision Rhinoplasty Palatopharyngoplasty Blepharoplasty (Uvulopalatopharyngoplasty, Uvulopharyngoplasty) Decompression of intervertebral disc (any method including nucleoplasty) Outpatient Physical/ Occupational/ Speech Therapy Transplants

Services for which precertification is required	
Tufts Health Plan Open Access EPO	United Choice EPO
<ul style="list-style-type: none"> • Abdominoplasty/pancicectomy • A.R.T. (Assistive Reproductive Technologies) services • Autologous chondrocyte implantation procedures: i.e., Carticel® • Auto-Set CPAP • Baclofen intrathecal infusion pump • Bilaminate skin substitute: i.e., Apligraf® • Blood pressure monitoring (ambulatory) • Blepharoplasty of the lower eyelid • Bone growth stimulator: electric • Bone growth stimulator: ultrasound • Botulin toxin injections: i.e., Botox • Bright light treatment: for the treatment of seasonal affective disorder • Cleft lip/palate repair for members 19 years or older • Cochlear implants • Collagen injection for urinary incontinence: i.e., Contigen® • Deep brain stimulation: unilateral and bilateral • Facial osteotomy • Gastric bypass/gastric stapling/gastric lap-band • Gastrointestinal capsule imaging • Genetic testing (except for Cystic Fibrosis and the following Ashkenazic Jewish panel: Tay-Sachs, Cystic Fibrosis, Canavan Disease, Niemann-Pick, Fanconi Anemia, Bloom Syndrome and Gaucher Disease) • Genioplasty • Gynecomastia surgery • Hemangiomas: surgical or laser treatment 	<ul style="list-style-type: none"> • Home prothrombin testing • Hyperbaric oxygen therapy except for emergency services • Hyperhidrosis: surgery • LASIK surgery: laser vision correction • Intrauterine fetal surgery • Intrauterine Insemination (IUI) when done in conjunction with donor sperm • Intravenous immunoglobulin (IVIG) • Low Density Lipoprotein (LDL) Apheresis • Maxillofacial surgery requiring hospitalization of a non-emergency basis • Nasal reconstruction • Occupational therapy • Oral devices for treatment of obstructive sleep apnea • Oral nutrition therapy • Oral surgery requiring hospitalization of a non-emergency basis • Orthognathic surgery • Osteogenesis distraction • Otoplasty • Pectus excavatum, pectus carinatum, Poland's Syndrome: surgical correction • Percutaneous vertebroplasty, kyphoplasty • Photorefractive keratectomy • Physical therapy for targeted diagnoses and for coverage beyond 30 visits • Pulsed dye laser surgery for treatment of port wine stains, or hemangiomas • Radial keratotomy • Reduction mammoplasty (breast reduction) • Removal of breast implants • Repair Brow Ptosis/Repair Blepharoptosis • Rhinoplasty, including septorhinoplasty • Rhinotomy • Sacral nerve stimulation for urinary dysfunction • Scar revision/excision, including keloids • Speech augmentation devices • Speech therapy • Spinal cord stimulator for pain management • Torn earlobe repair • Uterine artery embolization for treatment of fibroids • Ultraviolet light (UVB) home units: for treatment of psoriasis • Uvulectomy • Uvulopalatoplasty/Uvulopalatopharyngoplasty • Vagal nerve stimulation • Vests: high-frequency chest wall compression

United HealthCare provides coverage based on the benefits described in this summary plan description. There is no determination of medical necessity in the United Choice EPO.

Health and wellness

Health care benefits

Other covered medical services

The following is a list of other medical services covered under the medical plans listed in **Figure 3.0:**

- **Anesthetics:** Anesthetics, oxygen and their administration provided with a covered service
- **Dental Expenses:** Covered dental expenses include the following medically necessary services:
 - Treatment Due to Accidental Injury
 - Treatment for injuries to sound, natural teeth
 - The first replacement of fractured teeth with a crown or bridge as needed
 - Treatment of a fractured, dislocated or wounded jaw
 - Dental services performed in conjunction with medically necessary reconstructive surgery
 - Charges for repairing or replacing the first free standing crown or abutment for fixed bridge prostheses
 - Cancer
 - Dental services resulting from the direct treatment of cancer including and or repair/replacement of teeth extracted
 - Charges for first set of dentures needed as result of treatment of cancer
 - Transplant
 - Dental services resulting from transplant preparation
 - Dental services resulting from the initiation of immunosuppressives
 - Direct treatment of acute traumatic injury or cleft palate including teeth extraction or repair
- Cleft Palate/Congenital Anomaly
 - Treatment of congenitally missing, malpositioned (excludes routine orthodontic care covered under dental plan), supernumerary teeth, if part of a Congenital Anomaly (excluding implants)
 - Charges for the first set of dentures, repairing or replacing the first free standing crown or abutment for fixed bridge prostheses as a result of cancer, transplant, cleft palate treatment or congenital anomaly
- Dental services not covered include the following:
 - Dental care except as described above
 - Dental damage as a result of normal activities of daily living or extraordinary use of teeth
 - Routine Dental Care under a sponsored dental plan (preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums including the following:
 - Extraction, restoration and replacement of teeth
 - Medical or surgical treatments of dental conditions
 - Services to improve dental clinical outcomes)
 - Dental braces, dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia unless related to the above dental procedures covered under the medical plan.¹⁴

- **Doctor's visits:** To the home, office or hospital for a specific illness or injury other than a psychiatric condition

- **Internal prosthetic appliances:** Charges for purchase, maintenance or repair of internal prosthetic medical appliances consisting of permanent or temporary internal aids and supports for defective body parts, specifically intra-ocular lenses, artificial heart valves, cardiac pacemakers, artificial joints and other surgical materials, such as screw nails, sutures and wire mesh

- **Orthoptics:** For specific diagnosed eye muscle conditions, if performed as an alternative to surgery; requires a prescription from a physician detailing medical necessity

- **Orthotics:** Foot orthotics in accordance with medical necessity based on the diagnosis, with preapproval from the health plan

- **Prescription drugs:** Refer to the earlier section "Prescription drug benefits."

¹⁴ **Harvard Pilgrim HMO members:** Dental Emergencies are covered within the first 72 hours if medically necessary to prevent infection of sound, natural teeth loosened or fractured in the injury. Dental Emergency coverage includes an initial diagnostic exam, x-rays, extractions, suturing, and suture removal, re-implantation and/or stabilization of dislodged (avulsed) teeth, repositioning and/or stabilization of partially dislodged (subluxated) teeth.

Blue Cross Blue Shield Florida BlueCare HMO members: Accidental dental services are covered if rendered within 62 days after the accident.

What to do outside your Aetna Select EPO or regional HMO/EPO service area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. An urgent medical condition that occurs outside your health plan's service area can be treated in any of the above settings. You should call your preferred provider or PCP as soon as possible after receiving treatment.

What to do outside your Blue Cross Blue Shield EPO service area

Plan participants who are traveling outside the service area, or students who are away at school, are covered as if they were in their service area when they access a network provider in their location and for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. An urgent medical condition that occurs outside your health plan's service area can be treated in any of the above settings. You should call your preferred provider or PCP as soon as possible after receiving treatment.

If, after reviewing information submitted to your health plan by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. A health plan member services representative can take this information over the telephone.

Medical expenses not covered by the medical plans listed in Figure 3.0

Covered medical expenses do not include the following specific services, procedures and equipment:

- Ambulance services, when used as preventive transportation to receive inpatient or outpatient services
- Any service in connection with or required by a procedure or benefit not covered by the plan
- Any services or supplies that are not medically necessary, as determined by your health plan
- Aromatherapy
- Beam neurologic testing¹⁵
- Biofeedback, except in the management of certain conditions where biofeedback is of value as documented in applicable medical journals. In these situations, there is a maximum of 12 sessions per calendar year.¹⁶ Biofeedback is not covered for the treatment of the following conditions:
 - Treatment of ordinary muscle tension states, psychosomatic conditions, visual disorders
 - Essential hypertension
 - Anterior shoulder instability or pain
 - Attention deficit hyperactivity disorder
 - Anxiety disorders
 - Fibromyalgia
 - Intractable seizures
 - EMG biofeedback as a rehabilitation modality for spinal cord injury, spasmodic torticollis, or following knee surgeries
 - Myoexerciser 3 ambulatory EMG device for diagnosis or monitoring nocturnal bruxism in the treatment of TMJ
- Blood testing for allergies, including but not limited to: RAST, PRIST and RIST¹⁷ unless:
 - Direct skin testing is impossible because the patient has extensive dermatitis or marked dermographism.

¹⁵ Harvard Pilgrim HMO members: Beam neurologic testing is covered.

¹⁶ Harvard Pilgrim HMO members: Biofeedback is covered with no exceptions.

Blue Cross Blue Shield Florida BlueCare HMO members: Biofeedback is not covered.

¹⁷ Harvard Pilgrim HMO members: Diagnostic testing is covered. Investigational/Experimental testing is excluded.

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- Direct skin testing is impossible because the patient is age 4 or younger
- Direct skin testing is inconclusive and a further diagnostic test is necessary
- A history of severe anaphylactic allergy (for example, bee sting, peanuts, penicillin, etc.) exists
- Breast augmentation (unless reconstruction of a nonaffected breast is needed to achieve symmetry following a mastectomy) and otoplasties, including treatment of benign gynecomastia. Reduction mammoplasty is not covered unless medically necessary, as determined by your health plan, except following cancer surgery.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury
- Charges for canceled office visits or missed appointments
- Cosmetic surgery unless:
 - A person receives an injury that results in bodily damage requiring the surgery.
 - The surgery qualifies as reconstructive surgery performed on a person following surgery, is considered medically necessary and is provided by participating providers¹⁸.
 - Custodial services, domiciliary care, maintenance care, education or training
 - Cutting procedures of the mouth that are considered dental expenses
 - Dental services, except for those described under “Other covered medical services”
- Duplication of the RAST allergy test in patients less than 3 years of age¹⁹
- Educational services, special education, remedial education or job training. The plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems and learning disabilities are not covered by the plan. Developmental delay therapies are covered through age 6.²⁰
- Electrolysis
- Except for covered expenses under the prescription drug benefit, drugs and medicines not furnished and administered during confinement as a bed patient in a hospital or in a doctor’s office
- Expenses that are the legal responsibility of Medicare or a third-party payer
- Experimental, investigational and unproven services and procedures; ineffective surgical, medical, psychiatric or dental treatments or procedures; research studies; or other experimental, investigational or unproven health care procedures or pharmacological regimes, as determined by your health plan, unless approved by your health plan
- Eyeglasses, contact lenses and examinations for prescription or fitting thereof, except that covered expenses include the purchase of the first pair of contact lenses following cataract surgery²¹
- Food supplements, except when medically necessary and required for internal feedings that are the sole source of nutrition or provide a nutritional formula to treat a specific inborn error of metabolism
- Gastric Bypass surgery out of network
- Hair analysis²²
- Hypnosis
- Implantable drugs
- Modifications to your car due to a disability
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision), except as noted in the “Other covered medical services” section
- Orthotics, except as noted in the “Other covered medical services” section
- Private-duty nursing in the home or hospital
- Radial keratotomy, including related procedures designed to surgically correct refractive errors
- Recreational, educational and sleep therapy, including any related diagnostic testing²³
- Religious, marital and sex counseling, including related services and treatment
- Reversal of voluntary sterilizations, including related follow-up care
- Preventive hand and foot care services, including preventive reduction of nails, calluses and corns
- Preventive refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy and LASIK, when eyeglasses or contact lenses may be worn

¹⁸ **Harvard Pilgrim HMO members:** Cosmetic surgery for severe disfigurement is covered even if it is not the result of surgery, and a court order is not necessary.

¹⁹ **Blue Cross Blue Shield Florida BlueCare HMO members** and **Harvard Pilgrim HMO members:** This exception does not apply.

²⁰ **Blue Cross Blue Shield Florida BlueCare HMO members** and **Companion HMO South Carolina members:** Developmental delay therapies are not covered.

Harvard Pilgrim HMO members: Early interventions services are covered up to age 3.

²¹ **Harvard Pilgrim HMO members:** Additional vision hardware is covered for special conditions. Refer to section B.8 of your Harvard Pilgrim HMO handbook for details.

²² **Harvard Pilgrim HMO members:** This service is not excluded.

²³ **Harvard Pilgrim HMO members and Independent Health Care EPO members:** Sleep studies are covered.

- Services not covered by the plan, even when your participating provider has issued a referral for those services
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation
- Services provided by your close relative (your spouse, child, brother, sister or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made
- Services related to the diagnosis of temporomandibular joint (TMJ) disease or dysfunction, such as crowns, inlays/onlays/bridgework and appliances (unless otherwise indicated)
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; securing insurance coverage; travel and school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services
- Services that are not medically necessary as determined by the Medical Claims Administrator
- Special education, including lessons in sign language, to instruct a plan participant whose ability to speak has been lost or impaired, whether or not instruction is given in a facility that also provides medical or psychiatric treatment
- Speech therapy, if such therapy:
 - Is used to improve speech skills that have not fully developed, unless covered under the developmental delay benefit
 - Can be considered custodial or educational

- Is intended to maintain speech communication
and
- Is not restorative in nature.
- Sun and heat lamps, heating pads, special mattresses, pillows, shoes not attached to leg braces, vaporizers, humidifiers, steamers, air conditioners or purifiers
- Testing and storage of blood for future use²⁴
- Treatment by acupuncture or acupressure unless performed by a physician and used as anesthesia for covered surgery. If you participate in a regional HMO/EPO, contact your plan for information on acupuncture coverage.
- Treatment or services relating to the consequences or as a result of non-covered services
- Treatment of the teeth or periodontium, except as noted in "Other covered medical services" earlier in this section
- Treatment of weight control when an underlying severe medical condition is not present. Severe medical conditions include, but are not limited to, diabetes, hypertension, cardiovascular disease, etc.²⁵ In disputed cases, the plan reserves the right to make the final decision.
- Treatment or surgery to change gender or improve or restore sexual function
- Usual and normal home medical supplies or first aid items, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips
- Whirlpool or Jacuzzi equipment.

Mental health and chemical dependency limitations

The CIGNA Behavioral Health mental health and chemical dependency program does not cover the following services:

- Mental health treatment for the following conditions, except for the initial diagnosis and associated treatable and acute behavioral manifestations:
 - Mental retardation
 - Learning disorders
 - Pervasive developmental disorders
 - Chronic organic brain syndrome
 - Cognitive disorders
- Therapies that do not meet national standards for mental health professional practice, including but not limited to primal therapy, rolfing, sensitivity training, bioenergetic therapy and crystal healing therapy
- Treatment at unlicensed halfway houses or group homes
- Alternative residential programs, such as wilderness camps or military schools are excluded unless they are licensed in their state as a Residential Treatment Facility, provide 24-hour nursing care and have an on-site psychiatrist to provide weekly assessments.

Prescription drug limitations

No payment will be made for expenses incurred for:

- Administration of any drug
- Contraceptive devices and implants
- Drugs that do not require a written prescription by a physician, other than those specified under the "Prescription drug benefits" section
- Experimental drugs or substances not approved by the Food and Drug Administration and drugs labeled "Caution — limited by federal law to investigational use"
- Drugs that are not considered essential for necessary care and treatment of an injury or sickness, as determined by the medical plan administrator
- Drugs obtained from a nonparticipating mail order pharmacy

²⁴ **Harvard Pilgrim HMO members:** Collection and storage of cord blood is covered when clinical criteria are met.

²⁵ **Blue Cross Blue Shield Florida BlueCare HMO members:** Services for weight are excluded.

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- Drugs used for cosmetic purposes
- Immunization agents, biological sera, blood or blood plasma
- Indications not approved by the Food and Drug Administration
- Medication that is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution that operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription filled in excess of the number specified by the physician or dispensed more than one year from the date of the physician's order
- More than a 30-day supply when dispensed in any one prescription ordered through a retail pharmacy
- More than a 90-day supply when dispensed in any one prescription ordered through a participating mail order pharmacy
- Therapeutic devices or appliances, including hypodermic needles, syringes, certain support garments and other nonmedicinal substances, excluding insulin syringes
- Tretinoin for individuals age 37 and older, unless medically necessary as verified with prescriber.

Prescription benefit coverage for certain drugs may be approved or denied based on the uses for which those drugs are prescribed. Certain medications may be limited in the quantity that the plan will cover. Certain drugs may be subject to review to determine if alternative, cost effective therapies have been tried before they will be covered.

General limitations on covered medical and prescription drug expenses

No payment will be made for expenses incurred for:

- Charges made by an assistant surgeon in excess of 25% of the surgeon's allowable charge as determined as reasonable and customary or the negotiated fee as applicable. For purposes of this limitation, *allowable charge* is the amount payable to the surgeon before any reductions because of coinsurance or deductible amounts.
- Charges that exceed allowable amounts as determined as reasonable and customary or negotiated fees when two or more surgical procedures are performed during the course of a single operation. The allowable amount varies based on the procedures performed, the number of operative fields and the number of physicians involved.
- Charges made by any provider who is a member of your family or your dependent's family or who normally lives in your home or your dependent's home
- An illness or injury that is covered under any Workers' Compensation or similar law
- Charges made by a hospital owned or operated by, or which provides care or performs services for, the U.S. government, if the charges are directly related to a military service-connected sickness or injury
- Charges to the extent that payment is unlawful where the person resides when the expenses are incurred
- Charges that the person is not legally required to pay
- Charges that would not have been made if the person had no insurance
- Charges that are payable by Medicare if the Bank of America medical plan is the secondary payer
- Charges to the extent that they are more than reasonable and customary (R&C) charges
- Charges for care, treatment or surgery that is not medically necessary, as determined by the medical claims administrator
- Charges to the extent that you or any one of your dependents is in any way paid or entitled to payment of those expenses by or through a public program, other than Medicare or Medicaid
- Care for health conditions that are required by state or local law to be treated in a public facility
- Services provided by a Christian Scientist practitioner
- Experimental or investigational procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society
- Expenses incurred outside the United States or Canada, unless you or your dependent is a resident of either the United States or Canada, and the charges are unforeseen and incurred while traveling on business or for pleasure
- Services for equipment or supplies made or used for physical fitness, athletic training or to improve general physical condition
- Membership costs or fees associated with health clubs or weight loss clinics
- Services and supplies stipulated in a court order that would not otherwise be covered
- Expenses incurred after the date coverage in the plan ceases for you or your dependent for any reason, even though the expenses relate to a condition that began while you or your dependent was covered
- Treatment of an injury or sickness that is because of war, declared or undeclared

- Expenses associated with complications of noncovered services or procedures²⁶
- Any charge for illness or injury occurring in the commission of a crime by a covered individual²⁷
- Nonmedical ancillary services such as vocational rehabilitation, behavior training, sleep therapy, employment counseling, psychological counseling and training or educational therapy for learning disabilities or mental retardation. (Sleep studies are covered under the Independent Health Care EPO.)
- Emergency care charges made by a hospital emergency room or urgent care center, including ambulance charges, determined by the medical claims administrator not to be a true emergency
- Urgent care charges made by a hospital emergency room or urgent care center, including ambulance charges, determined by the medical claims administrator not to be truly urgent²⁸
- Charges to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
 - A no-fault insurance law
 - An uninsured motorist insurance law.

The medical plan will take into account any adjustment option chosen under such part by you or any one of your dependents.

- Immunizations, except for travel or work, and as described in the "Primary and preventive care" section.

Reimbursement for services under the medical plans listed in Figure 3.0

Aetna Select EPO, BCBS EPO, PPO in-network services and regional HMOs/EPOs

You do not have to file claim forms for services provided by a participating provider. The physician and/or facility will file these charges with the medical plan claims administrator for you.

PPO out-of-network services and non-network (indemnity) plans

Fast processing of your claim depends on complete and accurate information from you. To obtain reimbursement for your covered medical expenses:

- Complete the appropriate claim form.
- Print the form from Personnel Online at personnelonline.bankofamerica.com; select the Benefits tab and then Benefits Forms.
- Request the form from the Personnel Center.
- Request the form from your health plan.
- Attach an itemized bill from the physician showing the provider's name, the patient's name, the date of service, the condition being treated or diagnosed and the charge for the service or purchase.
- Use a separate claim form for each member of the family and for each separate accident, surgery or illness.
- Send your claims to the address listed on the claim form.

Important reminders

- You have one calendar year from the date of service to submit medical claims for processing for out-of-network services under the medical plan.
- Each incorrectly or unnecessarily submitted claim increases the administrative cost of your plan. If a clerical error results in a claim overpayment, the carriers have the

right to recover the overpayment from you and/or the provider.

- If a provider does not reimburse the plan for the overpayment, it is your responsibility to reimburse the plan.
- If you move, provide your new home address to the Personnel Center.
- If you also have coverage for your dependents, a maximum family deductible will apply. Any combination of covered expenses of the other family members can make up the remainder of the family deductible. You may also find it helpful to hold your medical bills until one member of your family has met the individual deductible; then send the claims in all at once. Also, use a separate claim form for each family member and for each separate accident, surgery or illness.

If you are disabled and enrolled in Medicare Parts A and B

- Your hospital and physician bills must first be sent to Medicare. Medicare processes the claim and sends you an explanation of the payment.
- Submit a copy of the same medical bills and the Medicare explanation of payment, along with a claim form, to the claims processing center.

Prescription drugs

If you or your dependent purchases covered prescription drugs from a participating retail pharmacy participating in the Caremark network, you pay only the copay shown in **Figures 3.1 and 3.2**. You do not need to file a claim form. Participants in the medical plans listed in **Figure 3.0** will receive a separate identification card from Caremark.

²⁶ **Harvard Pilgrim HMO members:** This service is not excluded.

²⁷ **Harvard Pilgrim HMO members:** Trauma is covered.

²⁸ **Harvard Pilgrim HMO members:** Harvard Pilgrim HMO pays all ER claims, based on location of service.

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How to fill prescriptions through a pharmacy

1. Select a pharmacy — Ask your pharmacist if the pharmacy participates in the Caremark program. You can also find a participating pharmacy near you by contacting Caremark by phone, or by logging on to www.caremark.com/bankofamerica. If you get your prescriptions filled at a pharmacy that is not part of the Caremark network, you will need to pay the pharmacist the entire cost of the prescription up front and submit a claim form to Caremark for reimbursement. You can request claim forms directly from Caremark or on Personnel Online.
2. Present your Caremark Identification Card to your pharmacist — Take both your card and prescription to the pharmacist.
3. Pay your portion of the medication cost — Your pharmacist will tell you the required copayment.

How to fill maintenance drug prescriptions by mail

1. When your doctor prescribes a maintenance drug, ask to have the prescription written for up to a 90-day supply with up to three refills.
2. If you need medicine at once, ask your doctor to write two prescriptions — one for you to fill right away at your local pharmacy, and a second to be sent to the mail service pharmacy for a long-term (maintenance) supply of your medicine.
3. For your first order, request a Caremark mail order form by calling Caremark or downloading a copy from www.caremark.com/bankofamerica and fill in the health history section of the form. (Legacy Bank of America associates can also download this form from Personnel Online.) For future orders, you can omit this section.
4. Complete an order form for new or refill prescriptions. A new order form and envelope will be sent to you with each delivery.
5. Either send a check payable to Caremark or provide your credit card number and expiration date.
6. Send your maintenance prescription, the completed order form and your payment to Caremark, PO Box 3223, Wilkes Barre, PA 18773-3223.
7. Allow 10–14 days from the date that you mail your order for delivery of your medicine. Overnight delivery is available for an additional charge.
8. To order refills, you can call Caremark directly to use the automated refill service or log on to www.caremark.com/bankofamerica. Have your prescription number, ZIP code and credit card information ready.

Subrogation and right of reimbursement under the medical plans listed in Figure 3.0

If you or one of your enrolled dependents is injured, there is potential for a claim against another person (a third party) for recovery of expenses or damages incurred from an injury or condition for which benefits were paid by the plan. A *third party* means any party possibly responsible for making any payment to the injured participant because of the injured participant's injury or condition, including any insurance coverage (for example, uninsured- or underinsured-motorist coverage, personal umbrella coverage, medical pay coverage, Workers' Compensation coverage or no-fault automobile insurance coverage).

You or your injured dependent must notify the medical plan claims administrator that there is such a potential or actual claim against a third party. The injured participant must provide in writing all facts related to the injury or condition and provide complete information regarding the potential or actual legal action or insurance claim to the medical plan claims administrator. The injured participant must also give the medical plan claims administrator prior notice of any intention to pursue or investigate a claim or of an intended settlement. The injured participant must cooperate with the efforts of the medical plan claims administrator to recover from the third party any benefits paid from the plan.



Upon paying or providing any benefits to the injured participant, the plan is subrogated to all rights of recovery the participant has against any third party, to the full extent of benefits provided by the plan. In addition, if the injured participant receives any payment from a third party because of an injury, the plan has the right to be reimbursed by the participant for all amounts the plan has paid and will pay for that injury, up to the amount the participant has received from all third parties.

The plan's subrogation and reimbursement rights are a first priority claim against all potential third parties and are to be paid to the plan ahead of any other claim for damages of the injured participant. This is so even if the remainder is insufficient to make the injured participant whole or compensate the participant in part or in whole for the damages sustained. The plan is not required to participate in or share in the cost of pursuing the damage claim, including attorney fees.

The subrogation and reimbursement provisions will apply regardless of whether liability for payment is admitted by the third party and regardless of whether any settlement, judgment or award received by the injured participant identifies the benefits the plan provided.

If the participant or dependent recovers from a third party the reasonable value of covered services rendered by a participating provider, the participating provider who rendered these services is not required to accept the amount paid by the health plan as payment in full, but may collect from the covered associate or dependent any difference between the amount paid by the medical plan and the amount collected by the participant or dependent for these services.

3

Where to find more information

If you have additional questions or need more information about the medical plans described in this handbook, please refer to the contact information shown in the following table:

For questions about...	Go online or call...
General Benefits Information	Personnel Online At work: personnelonline.bankofamerica.com At home: – Legacy Bank of America associates: resources.hewitt.com/bankofamerica – Legacy Fleet associates: www.netbenefits.com Personnel Center Legacy Bank of America associates: 1.800.556.6044 Legacy Fleet associates: 1.888.737.7661
Aetna Select EPO	www.aetna.com 1.800.548.3945
Aetna Choice II PPO	www.aetna.com 1.800.548.3945
Blue Cross Blue Shield EPO*	www.bcbsga.com/bankofamerica 1.866.765.6844
Blue Cross Blue Shield PPO*	www.bcbsga.com/bankofamerica 1.866.765.6844

*Administered by Blue Cross Blue Shield of Georgia

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For questions about...	Go online or call...
Blue Cross Blue Shield Out-of-Area*	www.bcbsga.com/bankofamerica 1.866.765.6844
Blue Cross Blue Shield High Deductible*	www.bcbsga.com/bankofamerica 1.866.765.6844
BlueChoice HMO Georgia*	www.bcbsga.com/bankofamerica 1.866.765.6844
Blue Cross Blue Shield Florida BlueCare HMO	www.bcbbsfl.com 1.800.320.7091
CIGNA Open Access HMO	www.cigna.com 1.800.244.6224
Companion HMO South Carolina	www.CompanionHealthCare.com 1.800.868.2528
Harvard Pilgrim HMO	www.harvardpilgrim.org 1.888.333.4742
Independent Health EPO	www.independenthealth.com 1.716.631.2661 or 1.800.257.2753
MVP Select Care EPO	www.mviselectcare.com 1.800.229.5851
Optima Health HMO Virginia	www.optimahealth.com 1.800.741.9910
Premera Blue Cross Foundation EPO	www.premera.com Premera: 1.800.722.1471 Medco: 1.800.391.9701 Mail order refills: 1.800.473.3455
Presbyterian EPO New Mexico	www.phs.org/members 1.800.356.2219 or 1.505.923.5678
Tufts Health Plan Open Access EPO	www.tuftshealthplan.com 1.800.801.3930
United Choice EPO	www.provider.uhc.com/bankofamerica 1.866.622.9270
Caremark – prescription drug coverage under the Aetna Choice II PPO, Blue Cross Blue Shield PPO, Aetna Select EPO, Blue Cross Blue Shield HMO/EPO and regional HMOs/EPOs listed in Figure 3.0	www.caremark.com/bankofamerica 1.800.701.5833
CIGNA Behavioral Health – mental health/chemical dependency benefits under the Aetna Choice II PPO, Blue Cross Blue Shield PPO, Aetna Select EPO, Blue Cross Blue Shield HMO/EPO and regional HMOs/EPOs listed in Figure 3.0	www.cignabehavioral.com 1.888.734.3453

*Administered by Blue Cross Blue Shield of Georgia

Dental coverage

Dental coverage offers preventive care and assistance with treatments such as fillings, dentures and children's orthodontia. You may elect coverage under one of two types of dental plans — the Aetna Dental Maintenance Organization (DMO), which works much like a medical health maintenance organization, if available in your area, or the MetLife Dental Plan, which operates like a traditional plan.

Figure 3.3 shows the benefits for the Aetna DMO (using a participating provider) and the benefits under the MetLife Dental Plan.

Aetna Dental Maintenance Organization (DMO)

With this plan, there are networks of individual dentists in private practice who agree to provide services to their members for negotiated fees. DMOs and their dentists stress effective and efficient care while they address patients' dental needs and encourage continued dental maintenance. A reduced coverage level is available for dentists that are out-of-network for associates who are located in all states except Arizona, California, New Jersey, Texas and North Carolina. For more information on non-participating benefits, please contact Aetna at **1.800.843.3661**.

Under the Aetna DMO:

- There is no deductible.
- There are no annual dollar maximums.
- There is a \$5 copayment for office visits.
- There are no claim forms (for most services).
- Orthodontia coverage is for covered children who are under the age of 20 on the date that orthodontic treatment begins.

In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist (PCD) selected from the network of participating DMO dentists. Frequency and/or age limitations may apply to these services.

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Figure 3.3

Dental benefits schedule for associates and covered dependents

	Aetna DMO In network*	MetLife Dental Plan In- and out-of-network
Annual deductible amount (includes combined expenses for basic and major care)		
Individual	None	\$50
Family	None	\$150
Covered percentage		
Preventive	100% after \$5 copay	100%
Basic	80%	80% after deductible is met
Major	60%	60% after deductible is met
Orthodontia (child up to age 19 only)	50%	50%
Maximums		
Calendar year maximum for covered dental expenses other than orthodontia	No limit	\$1,500
Lifetime maximum for orthodontic treatment	No limit	\$1,500

*You generally must use a network provider to receive benefits under the Aetna DMO. However, a small benefit may apply in some states if a non-network dental provider is used.

Health and wellness

Health care benefits

**Covered dental services under the Aetna DMO****Preventive care**

- Oral exams, not more than four in a calendar year
- Cleanings, including scaling and polishing, not more than twice per year
- One fluoride treatment per year for dependents through age 17
- Sealants on permanent molars: one application every three years for dependents up to age 16
- X-rays:
 - Bitewing X-rays; not more than two sets per year
 - Full-mouth series X-rays; not more than once every three years.

Basic care

- Root canal therapy with X-rays and cultures for anterior and bicupid teeth
- Amalgam (silver) fillings
- Composite fillings for anterior teeth only
- Stainless steel crowns
- Scaling and root planing, not more than four separate quadrants per year
- Gingivectomy
- Incision and drainage abscess
- Extractions (must be uncomplicated)
- Surgical removal of erupted tooth or impacted tooth (soft tissue).

Major care

- Space maintainers
- Root canal therapy of molar teeth with X-rays and cultures
- Osseous surgery
- Surgical removal of impacted tooth (partial bony/full bony)
- General anesthesia/intravenous sedation
- Inlays, onlays and crowns
- Full and partial dentures and denture repairs
- Pontics.

Specialty referrals

- Under the Aetna DMO, services performed by a specialist are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental.
- DMO members may visit an in-network orthodontist without first obtaining a referral from their primary care dentist.

Emergency care

- If you need emergency dental care for palliative treatment, such as pain relieving or stabilizing a dental emergency, you are covered 24 hours a day, seven days a week.
- Contact your primary care dentist to receive treatment.
- If you are unable to contact your PCD, or you are more than 50 miles from your home address, contact Aetna member services for assistance in locating a dentist.

Exclusions under the Aetna DMO

- Services or supplies that are covered in whole or in part under any other plan or group benefits provided by or through Bank of America
- Services and supplies to diagnose or treat a disease or injury that is not non-occupational
- Services not listed in the applicable Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate. For a complete copy of the Booklet-Certificate please contact Aetna Member Services at **1.800.843.3661**.
- Replacement of appliances that are lost, missing or stolen or have been damaged due to abuse, misuse or neglect
- Plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

- Services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals
- Dentures, crowns, inlays, onlays, bridgework, or other appliance or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion
- An appliance or modification of one if an impression for it was made before the person became a covered person
- A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person
- Root canal therapy if the pulp chamber for it was opened before the person became a covered person (does not apply to the Aetna DMO in Texas)
- Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
- Services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth
- Orthodontic treatment, unless otherwise specified in the Booklet-Certificate
- General anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, the services will not be eligible for benefits unless done in conjunction with another necessary covered service.
- Treatment by someone other than a dentist, except for scaling or cleaning of teeth and topical application of fluoride, which may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

- Service given to a person age 5 or older if that person becomes a covered person other than: (a) during the first 31 days the person is eligible for this coverage, or (b) as prescribed for any period of open enrollment agreed to by the Bank of America and Aetna. This does not apply to charges incurred:
 - After the end of the 12-month period starting on the date the person became a covered person; or
 - As a result of accidental injuries sustained while the person was a covered person; or
 - For a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology
- Services given by a non-participating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies
- A crown, cast or processed restoration unless:
 - It is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
 - The tooth is an abutment to a covered partial denture or fixed bridge.
- Pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate
- Services needed solely in connection with non-covered services
- Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any applicable law.

Other rules applicable to the Aetna DMO

Replacement rule

The replacement of, addition to, or modification of existing dentures, crowns, casts or processed restoration, removable denture, fixed bridgework or other prosthetic services is covered only if one of the following terms is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.
- The existing denture, crown, cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least five years before its replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth missing but not replaced rule

Coverage for the first installation of removable dentures, fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures, fixed bridgework and other prosthetic services are:

- Needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and
- Are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior five years.

Health and wellness

Health care benefits

MetLife Dental Plan

With this plan, you can use the dental provider of your choice. However, if you use a dental provider that participates in the MetLife dental network, you have the advantage of lower rates negotiated by MetLife with participating providers, and reasonable and customary limits do not apply. In addition, there are no claim forms to file; your network dentist is paid directly by the plan.

When you receive care from a non-network provider, the plan will pay benefits based on what is considered the reasonable and customary charge for a particular service. If the provider charges more, you will be responsible for paying the amount that exceeds the reasonable and customary limit plus the applicable coinsurance and deductible. In addition, you generally will need to pay for your care at the time of your visit and submit a claim for reimbursement.

Here's an example of how you can save by using a network provider. Suppose you need a filling (which is considered "basic care" under the plan). If you receive care from a network provider, the plan will pay 80% of the lower, negotiated rate after you meet the deductible, and you will pay the remaining 20% of the negotiated rate. If you receive care from a non-network provider and you've met the deductible, the plan will pay 80% of the full amount charged by your provider up to reasonable and customary limits. You will then pay 20% of the provider's charge plus any amount that exceeds the reasonable and customary limits. Since you are paying a percentage of a lower rate when you go in-network, you will save money by using a network provider.

Important notes

- Expenses for orthodontia, including any procedures necessary for such treatment, are considered covered dental expenses only if the dependent child is younger than 19.
- If you expect a dental bill to be \$300 or more, see "Predetermination of benefits" later in this section.

Definitions for the MetLife Dental Plan

- **Calendar year** means a period that starts on any January 1 and ends on the next December 31.
- **Covered percentage** means the percentage(s) shown under "MetLife Dental Plan" in **Figure 3.3**, "Dental benefits schedule for associates and covered dependents."
- **Deductible amount** is the amount shown under "MetLife Dental Plan" in **Figure 3.3**, "Dental benefits schedule for associates and covered dependents." Annual deductibles for covered dental expenses are paid by you before full or partial expense reimbursement begins.
- **Dentist** means a person licensed to practice dentistry.
- **Participating dental provider** means a dentist who has agreed to participate in the plan's dental network. Participating providers have agreed to accept a schedule of maximum fees as payment in full for services rendered. Generally, this means lower out-of-pocket expenses for you and your family.
- **Participating dentist program directory** means the periodically updated list of selected dentists who are:
 - Located in your area
 - Participating providers who have agreed to accept negotiated rates as payment in full for services rendered.

MetLife Dental Plan payments

Covered dental expenses must be:

- Performed or prescribed by a dentist
- Necessary as determined by the plan in terms of generally accepted dental standards.

For in-network benefits, charges are based on the standard preferred dentist program table of maximum allowed charges for dental services shown in the "Covered dental services under the MetLife Dental Plan" section that follows. No more than the maximum allowed charge for dental services shown in the "Covered dental services under the MetLife Dental Plan" section will be covered.

The maximum allowable charge is the lower of:

- The amount charged by the participating provider for the service or supply
- The maximum amount that the participating provider has agreed with the plan to charge for the service or supply. This maximum amount is specified or based on the amount specified in the standard preferred dentist program table of maximum allowable charges.

For out-of-network benefits, no more than the reasonable and customary charge is eligible.

The reasonable and customary charge is the lowest of:

- The usual charge by the dentist or other provider for the services or supplies for the same or similar services or supplies
- The usual charge of most other dentists or other providers in the same geographic area for the same or similar services or supplies, as determined by the plan
- The actual charge for the services or supplies.

There may be more than one way to treat a dental problem. If, as determined by the plan, an adequate method or material that costs less could have been used, the benefit will be based on that lower cost. The rest of the cost is not covered. See "Alternate benefits" later in this section for examples.

Covered dental services under the MetLife Dental Plan

Preventive care

- Oral exams, not more than twice in a calendar year
- X-rays:
 - Full-mouth X-rays; not more than once every three years
 - Bitewing X-rays; not more than twice in a calendar year
- Routine scaling and polishing of teeth (oral prophylaxis), not more than twice in a calendar year, for "routine cleaning," not deep periodontal cleaning
- Topical fluoride treatment for a dependent child younger than 19, not more than twice in a calendar year
- One application of sealant material for each nonrestored permanent molar tooth of a dependent child at least six years old but not over age 19; not more than once in three years
- Emergency palliative treatment
- Instruction for oral care such as hygiene or diet, but not more than twice in a calendar year.

Basic care

- Fillings: amalgam, silicate or resin fillings
- Extractions (must be uncomplicated)
- Root canal treatment, no more than one time for the same tooth in a calendar year
- Periodontal maintenance, where periodontal therapy (such as osseous surgery, gingivectomy, gingivoplasty or gingival curettage) has been previously performed. The combined total number of covered oral prophylaxes will not exceed four treatments in a calendar year.
- Treatment of periodontal disease (other than by periodontal maintenance) and treatment of other diseases of the gums and tissues of the mouth
- Space maintainers for a dependent child younger than 19
- Oral surgery
- Administration of general anesthesia when necessary as determined by the plan in terms of generally accepted dental standards for oral surgery, extractions or other covered dental services
- Injections of antibiotic drugs
- Relinings and rebasings of existing removable dentures, not more than once in 36 months
- Repair or recementing of crowns, inlays, onlays, dentures or bridgework.

Major care

- Those services needed to replace one or more natural teeth which are lost while the plan for the covered person is in effect:
 - Installation of fixed bridgework done for the first time
 - Installation for the first time of a partial removable denture or a full removable denture

- Replacing an existing removable denture or fixed bridgework if it is needed because the existing denture or bridgework is no longer serviceable and was installed at least five years earlier
- Replacing an existing-immediate temporary full denture by a new permanent full denture when the existing denture cannot be made permanent and the permanent denture is installed within 12 months after the existing denture was installed
- Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed
- Inlays, onlays and crown restoration, not more than one such restoration to the same tooth surface within five years of the prior restoration
- Bruxism; coverage for the appliance to treat bruxism limited to one every two years with a lifetime maximum of four appliances.

Orthodontia

- Orthodontia, including appliance therapy for a dependent child younger than 19. The aggregate maximum benefit for orthodontia is shown under "MetLife Dental Plan" in **Figure 3.3**, "Dental benefits schedule for associates and covered dependents."

Exclusions under the MetLife Dental Plan

- Services or supplies received by a covered person before the dental expense benefits start for that person
- Services not performed by a dentist, except for those services performed by a licensed dental hygienist that are supervised and billed by a dentist and are not for scaling or polishing of teeth or fluoride treatments

Health and wellness

Health care benefits

- Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn dependent child
- Replacement of a lost, missing or stolen crown, bridge or denture
- Services or supplies that are covered by any Workers' Compensation laws or occupational disease laws
- Services or supplies that are covered by any employers' liability laws
- Services or supplies that any employer is required by law to furnish in whole or in part
- Services or supplies received through a medical department or similar facility that is maintained by the covered person's employer
- Repair or replacement of an orthodontic appliance
- Services or supplies received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person
- Services or supplies that a covered person is not required to pay
- Services or supplies that are deemed experimental by generally accepted dental standards
- Services or supplies received as a result of dental disease, defect or injury from an act of war or a warlike act in time of peace
- Adjustment of a denture or bridgework that is made within six months after installation by the same dentist who installed it
- Any duplicate appliance or prosthetic device
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride
- Periodontal splinting

- Services or supplies to the extent that benefits are otherwise provided by this plan or any other plan that the employer or an affiliate contributes to or sponsors
- Myofunctional therapy or correction of harmful habits
- Implants
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before the dental expense benefits started for the covered person or as a replacement for congenitally missing teeth
- Charges for broken appointments
- Charges by the dentist for completing dental forms
- Treatment of temporomandibular joint disorder
- Sterilization of supplies
- Services or supplies furnished by a family member.

Alternate benefits

Dental benefits are based on the materials and method of treatment that cost the least and that, as determined by the plan, meet generally accepted dental standards. To determine the amounts of covered dental expenses, the plan may ask for X-rays and other diagnostic and evaluative materials. If they are not provided, the plan may determine the covered dental expense based on the information that is available and this may reduce the amount of benefit paid.

Inlays, onlays, crowns and gold foil

- If a tooth can be repaired, as determined by the plan according to generally accepted dental standards, by a less costly method than an inlay, onlay, crown or gold foil, your dental benefit is based on the adequate method of repair that costs the least.

Crowns, pontics and abutments

- Veneer materials may be used for front teeth or bicuspids. However, your benefit is based on the adequate veneer materials that cost the least.

Bridgework and dentures

- Your dental benefit is based on the adequate method of treating the dental arch that costs the least.
- In some cases, removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, your dental benefit will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To determine the plan coverage for other possible treatments, see "Predetermination of benefits."

Predetermination of benefits

If a dental bill is expected to be \$300 or more, you can find out what benefit will be paid before treatment starts. To do this, send to the plan a regular claim form in which the dentist indicates:

- The work to be done
- What the cost will be.

After the plan reviews the claim form, you will be told by the plan what benefit will be paid. If you do not use this method, the benefit payment decision will be final and binding.

This method should not be used for:

- Emergency treatment
- Routine oral exams
- X-rays, scaling, polishing and fluoride treatments
- Dental services that cost less than \$300.

Payment of covered benefits

Payable dental benefits are paid either directly to the dentist, if you have directed the plan to do so, or paid to you. The plan pays benefits when the plan receives satisfactory written proof of your claim. Proof must be given to the plan by March 31 of the year following the calendar year in which the covered dental expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as proof is given as soon as possible.

Coordination of benefits under duplicate coverage

Duplicate coverage occurs when an associate and/or family members are covered by more than one dental plan. If, for instance, a husband and wife both receive dental insurance coverage through their employers, they and their family members may be covered by more than one group plan. This kind of duplication can result in two plans covering the same expenses. The following information below describes how benefits are paid when there is duplicate coverage.

The primary plan is the plan that pays a benefit first. If you and your dependent children are covered by the MetLife Dental Plan and your spouse or domestic partner covers you and your enrolled dependent children in his or her group plan, specific rules determine which plan is the primary plan. The group plan that covers a Bank of America associate's spouse or domestic partner as an active employee is considered his or her primary plan. Similarly, the plan that covers you as an associate is considered your primary plan.

If your spouse or domestic partner's plan follows the same rules, the MetLife Dental Plan pays first when the covered expense is for services provided to you. Benefits for enrolled dependents are paid in this order:

- Your covered children have eligible expenses and your birthday falls earlier in the calendar year than your spouse or domestic partner's birthday.
- Your covered children have eligible expenses and you and your spouse or domestic partner have the same birthday, but you have had Bank of America coverage longer than your spouse or domestic partner has had his or her coverage.

If your spouse or domestic partner's dental plan does not have these same rules, both plans will be reviewed to determine the order of payment.

- For children of divorced or separated parents, the order of benefits is:
 - The dental plan of the parent with custody of the child
 - The dental plan of the new spouse, if the parent with custody has remarried
 - The dental plan of the parent who does not have custody
 - The dental plan of the spouse of the parent who does not have custody
 - In all cases, if a court decree states that one parent is responsible for paying dental expenses for the child, the court decree is followed.
- If the plan of the Bank of America associate's spouse or domestic partner is the primary plan, once the primary plan has paid the benefits under that plan, the bank associate's plan pays the difference between the primary plan's payment and the allowable expense. For purposes of this coordination provision, *allowable expense* means any reasonable and customary charge that:
 - Is a charge for an item of necessary dental expense

- Is an expense that a covered person must pay
- Is an expense that is at least partly covered by at least one of the plans that covers the person for whom the claim is made.

- When a plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits in that plan are allowable expenses.
- When a plan provides benefits in services rather than cash payment, the reasonable cash value of each service rendered is both an allowable expense and a benefit paid.

However, allowable expenses do **not** include:

- Expenses for services rendered because of sickness or injury for which benefits are paid or payable under any Workers' Compensation law
- Any amount of benefits reduced by a primary plan because the covered person does not comply with the plan provisions. Examples of such provisions are those related to:
 - Second surgical opinions
 - Precertification of admissions or services
 - Preferred provider arrangements.

Only benefit reductions based on provisions similar in purpose to those described in the prior sentence and that are contained in the primary plan may be excluded from allowable expenses. This provision will not be used by a secondary plan to refuse benefits payments because a member has elected to have dental care services provided by a nonprovider and the plan, pursuant to its contract, is not obliged to pay for providing those services.

Health and wellness

Health care benefits

- When you or your enrolled dependents are covered by two plans, the claim form should be sent to the primary plan first. After the primary plan pays, copies of the same bills and the settlement sheet (or explanation of benefits) you received from the primary plan should be sent to the secondary plan. It is your obligation to notify the claims administrator if you have other coverage. The plan of the parent with the earliest birth date in the calendar year is primary for services for dependent children. This procedure will apply to all covered services, including those for which you have submitted for preservice review.
- The standard filing limits which apply to all other claims apply under duplicate coverage as well.

Effect of government plans on dental expense benefits

To the extent that services or supplies, or benefits for those services or supplies, are available to a covered person under a government plan as defined below, they are not considered for benefits under this plan. This provision does not apply to a government plan if that plan requires that benefits be paid under this plan first.

A *government plan* is any plan, program or coverage other than Medicare:

- That is established under the laws or the regulations of any government **or**
- In which any government participates other than as an employer.

and

- The crown is installed within 31 days after the date the dental coverage ends.
- For root canal therapy if:
- The dentist opened the tooth while the dental coverage was in effect **and**
- The treatment is finished within 31 days after the date the dental coverage ends.

Additional information

You can obtain benefit summaries for these plans on Personnel Online at personnelonline.bankofamerica.com or you may contact the dental plan directly. Benefit plan certificates of coverage are available from the dental plan at the telephone number listed on the benefit summary.

Dental expense benefits after coverage ends

No benefits are payable for covered dental expenses incurred after dental coverage for that person ends. This applies even if the plan has predetermined benefits for dental services.

However, benefits for covered dental expenses incurred for the following services are paid after dental coverage ends:

- For a prosthetic device if:
 - The dentist prepared the abutment teeth and made impressions while dental coverage was in effect **and**
 - The device is installed within 31 days after the date the dental coverage ends.
- For a crown if:
 - The dentist prepared the tooth for the crown while the dental coverage was in effect

Vision coverage

Bank of America offers vision benefits that provide care through three different networks of optometrists and ophthalmologists, contracted to provide services at discounted rates. The plans provide routine eye care, including lenses, frames or contacts.

Plan descriptions

You are not required to select a primary vision provider. However, if you have an eye doctor that you see regularly, you may want to contact that office to determine if he or she participates in one of the networks. You may view a list of participating providers affiliated with these plans by logging on each plan's Web site from work through Personnel Online at personnelonline.bankofamerica.com, or from home at resources.hewitt.com/bankofamerica for legacy Bank of America associates and www.netbenefits.com for legacy Fleet associates. For more information about a specific plan, contact your plan provider.

Cole Managed Vision

- Care is provided through a nationwide network of approximately 8,500 optometrists and ophthalmologists in certain retail outlets.
- Most network locations are full service with dispensing capabilities. Retail locations offer evening and weekend hours for your convenience.
- When you use a network provider, there are no claim forms to file.

Simply present the ID card mailed to you, or identify yourself as a Bank of America associate/dependent when you receive a service. Your network provider will file your claim for you. Services are accessible even if your ID card is not available.

- If you go to an out-of-network provider, you will need to pay the provider in full at the time services are received and then file a claim for reimbursement. A claim form must be submitted with an itemized receipt for reimbursement. Claim forms may be obtained at www.colemanagedvision.com or by calling **1.800.334.7591**. Mail your claim form and a copy of your itemized receipt to: Cole Vision Services, PO Box 8056, Twinsburg, OH 44087.

Vision Service Plan (VSP)

- Care is provided through a network of approximately 22,000 private-practice optometrists and ophthalmologists nationwide.
- All services are available at every location during standard office hours. Saturday and evening hours may be available, as well as 24-hour message services.
- There is no ID card or claim form to file when you visit a VSP network doctor. Once you make an appointment and tell the doctor you are a VSP member, your doctor and VSP will handle the rest.
- For out-of-network claims, log onto www.vsp.com, select the "Out-of-Network Reimbursement Form" and follow the instructions. If you do not have Internet access, send an itemized receipt listing the services received

along with the patient's name and covered member's name and ID number to VSP. Out-of-network claims must be submitted to VSP within six months. Keep a copy of the claim and send the originals to: VSP, PO Box 997105, Sacramento, CA 95899-7105.

VisionCare Plan (VCP)

(only available to associates who live in Florida)

- Care is provided through a network of approximately 14,000 private practice optometrists and ophthalmologists.
- All services are available at every network location during standard medical office hours. Many locations also have evening and weekend hours.
- When you use a network provider, there are no claim forms to file. Simply present your ID card when you receive a service, and your network provider will be responsible for the rest.
- If you go to an out-of-network provider, you will need to pay the provider in full at the time services are received and then file a claim for reimbursement. To be reimbursed, you will need to mail a detailed receipt to the VCP Claims Department along with the following information:
 - The covered associate's name, Social Security number, mailing address and name of employer
 - The patient's name and date of birth.

This information should be mailed to: 1511 N. Westshore Boulevard, Suite 1000, Tampa, FL 33607, Attention: VCP Claims.

Plan	Where to Call or Go Online
Cole Managed Vision	1.800.334.7591 www.colemanagedvision.com
Vision Service Plan (VSP®)	1.800.877.7195 www.vsp.com
VisionCare Plan (VCP) (Florida only)	1.800.299.2510 www.visioncare.com

Health and wellness

Health care benefits

Figure 3.4 summarizes in- and out-of-network benefits for the vision plans.

Figure 3.4

Vision plan benefits						
	Cole Managed Vision		VSP		VisionCare Plan (Florida Only)	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Exams	Covered at 100% after \$10 copay; limited to one exam once per calendar year including a contact lens exam with fitting and follow-up fees	Reimbursed up to \$40 and limited to one exam per calendar year	Covered at 100% after \$10 copay; limited to one exam once every 12 months	Reimbursed up to \$40 and limited to one exam once every 12 months	Covered at 100% after \$10 copay; limited to one exam every 12 months	Reimbursed up to \$40 and limited to one exam every 12 months
Eyeglass lenses	Single vision, bifocal, trifocal and lenticular standard uncoated plastic lenses are covered at 100% once per calendar year. Additional discounts up to 65% apply to lens options and additional eyewear throughout the benefit year.	Once per calendar year, reimbursed up to: Single vision, \$40 Bifocal, \$60 Trifocal, \$80 Lenticular, \$125	Single vision, bifocal, trifocal and lenticular standard uncoated plastic lenses are covered at 100% once per calendar year. An additional 20% discount applies to lens extras, such as scratch-resistant coatings.	Once every 12 months, reimbursed up to: Single vision, \$40 Bifocal, \$60 Trifocal, \$80 Lenticular, \$125	Single vision, bifocal, trifocal and lenticular standard uncoated plastic lenses are covered at 100% once per calendar year.	Once every 12 months, reimbursed up to: Single vision, \$40 Bifocal, \$60 Trifocal, \$80 Lenticular, \$125
Frames	Covered at 100% up to \$130 and provided every calendar year, when necessary. Certain limitations and exclusions apply.	Reimbursed up to \$45 and provided once every calendar year when necessary. Certain limitations and exclusions apply.	Covered at 100% up to \$130 and provided every calendar year, when necessary. A 20% discount on any out-of-pocket costs of the frame and additional prescription glasses (lenses and frames) Certain limitations and exclusions apply.	Reimbursed up to \$45 and provided once every 12 months when necessary. Certain limitations and exclusions apply.	\$50 wholesale allowance and provided once every calendar year, when necessary. Certain limitations and exclusions apply.	\$50 allowance and provided once every 12 months, when necessary. Certain limitations and exclusions apply.
Elective contact lenses	The plan will allow up to \$125 toward the cost of contact lenses in lieu of lenses and frames once every calendar year.	The plan will allow up to \$105 toward the cost of contact lenses in lieu of lenses and frames once every calendar year.	The plan will allow up to \$125 toward the cost of contact lenses in lieu of lenses and frames once every calendar year; applies to lens evaluation, fitting, materials, and follow-up evaluation.	The plan will allow up to \$105 toward the cost of contact lenses in lieu of lenses and frames once every calendar year; applies to lens evaluation, fitting, materials, and follow-up evaluation.	The plan will allow up to \$125 toward the cost of contact lenses in lieu of lenses and frames once every calendar year; applies to lens evaluation, fitting, materials, and follow-up evaluation.	The plan will allow up to \$125 toward the cost of contact lenses in lieu of lenses and frames once every calendar year; applies to lens evaluation, fitting, materials, and follow-up evaluation.

Vision plan benefits						
	Cole Managed Vision		VSP		VisionCare Plan (Florida Only)	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Medically necessary contact lenses	Covered at 100%, no copay	Reimbursed up to \$210 if authorized	Covered at 100%, no copay	Reimbursed up to \$210 if authorized	Covered at 100%, no copay	Reimbursed up to \$210 if authorized, once every 12 months
LASIK surgery	Discount offered; includes custom treatments at varied discount rates	Not covered	Discount offered; a limit of \$1,800 per eye for a lifetime	Not covered	You must use a contracted facility. The plan offers a discount limited to 15% or \$1,800 per eye.	Not covered
Photorefractive Keratectomy (PRK) surgery	Discount offered; includes custom treatments at varied discount rates	Not covered	Discount offered; limited of \$1,500 per eye for a lifetime	Not covered	You must use a contracted facility. The plan offers a discount limited to 15% or a cost of \$1,800 per eye.	Not covered



Health and wellness

Illness, injury and disability benefits

Illness, injury and disability benefits

Overview

Bank of America offers the following benefits to eligible associates who are unable to work for medical reasons:

- Occasional illness days
- Short-term disability (STD)
- Long-term disability (LTD)
- Workers' Compensation for work-related illness or injury
- Long-term care insurance.

Occasional illness days

The occasional illness policy provides paid time off from work if you are a full- or part-time associate and must be absent because of personal illness or injury or to care for a spouse, domestic partner, child (including the child of your spouse or domestic partner) or parent who is ill or injured.

In general, commissioned associates, associates working fewer than 20 hours per week and associates in bands 0–3 are not eligible for occasional illness days.

To request time off due to illness, you should notify your supervisor or manager before your normal starting time, if possible.

If you can't work for medical reasons because of illness, injury or pregnancy disability, you are paid any occasional illness days you have available. The amount of pay you receive for each occasional illness day is the difference between your current daily rate of pay and any Workers' Compensation benefits available to you.

Eligible associates can accrue 10 occasional illness days per calendar year. Two of these days can be used for personal reasons with prior manager approval.

For part-time associates these days are pro-rated based on their regularly scheduled weekly hours. For example, an associate who is scheduled to work 25 hours a week would be eligible for 50 hours of sick time for the calendar year ($\frac{25}{40} = .625$ and .625 multiplied by 80 hours = 50 hours).

You accrue a portion of your annual amount of occasional illness days each pay period in which you work or receive paid time off, proportionate to your number of pay periods per year. For example, if you are paid twice a month, you accrue $\frac{1}{24}$ of your annual amount of occasional illness days each pay period.

There is no carryover of unused occasional illness days from one calendar year to the next. Occasional illness days are available for use at the beginning of each calendar year. However, occasional illness days you have taken, but not yet accrued, will be considered a pay advance. Therefore, at year-end, this amount may be reconciled from your pay, or otherwise recovered from you, to the extent permitted by law. If you leave the company, the amount may be reconciled from your final pay, or otherwise recovered from you, to the extent permitted by law. No payment will be made for any accrued but unused occasional illness days.

Even if you are eligible for paid benefits, your medical absences may be counted under your unit's attendance policy (as permitted by law).

Special provision for former BankAmerica associates

- You retained your "sickness benefit days" accrued as of December 31, 2000. After this date, no additional "sickness benefit days" accrued. (Former Washington Division (Seafirst) associates retained "sickness benefit days" accrued as of March 17, 2002.)
- If you use all of your 10 occasional illness days, you may use any unused accrued "sickness benefit days" for personal illness in the manner authorized by the company.
- These "sickness benefit days" will continue to be reconciled with any available state disability insurance (SDI) or Workers' Compensation benefits.
- If you qualify for STD pay, see "Coordination with other benefits" under "Short-term disability" below.
- If you leave the company for 180 days or more and are rehired, your sickness benefit days will not be reinstated.

Short-term disability (STD)

Short-term disability provides income protection if you are unable to work for more than seven consecutive calendar days due to illness, injury or pregnancy disability. Income is replaced up to either 100% or 70% of base pay after taxes for the period shown in **Figure 3.5**, when combined with any available Workers' Compensation benefits and state disability insurance payments.

Eligibility

The short-term disability benefit is for full-time and part-time associates who have completed at least one year of continuous service and who are unable to work for more than seven consecutive calendar days. You will have a break in your continuous service if your employment ends for 180 days or more.

The STD benefit is not available for associates to use to attend to family members who have an illness.

You are considered disabled if you meet the following requirements:

- Due to sickness, injury or pregnancy, you are receiving appropriate care and treatment from a licensed physician on a continuing basis.

- You are complying with such treatment.
- You are unable to perform all the material and substantial duties of your occupation.

For purposes of determining whether a disability is the direct result of an accidental injury, the disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes. If the associate's occupation requires a license, the fact that the license is lost for any reason will not, in itself, constitute disability.

STD benefits

If you are an eligible associate who is unable to work for more than seven consecutive calendar days, beginning on the eighth day of the disability you may receive 100% of your base pay for up to eight weeks and then 70% of your base pay for up to an additional 17 weeks, as shown in **Figure 3.5**.

For commissioned associates, STD pay will be based on the annual base pay determined for you by the company for benefits purposes.

If your employment ends while you are receiving STD benefits, STD pay stops.

STD pay

- If you are a full-time associate, one week of STD pay is equal to your weekly base pay.
- If you are a part-time associate, your weekly STD pay is based on your weekly projected average hours (entered as weekly scheduled hours on the payroll system).

Coordination with other benefits

- The first seven days of your disability are considered a waiting period. This waiting period will be funded with your available occasional illness days and sickness benefit days, if applicable. You may also be able to use your available vacation and purchased time off. If funding is not available, this time is unpaid.
- Bank of America STD benefits are offset by other disability benefits you are eligible to receive, such as Workers' Compensation and state disability insurance benefits.

Figure 3.5

Week of disability	STD pay
1	Waiting period
2–8	100% of base pay
9–26	70% of base pay

Health and wellness

Illness, injury and disability benefits

- If you are a former BankAmerica associate and qualify for STD benefits and you have unused “sickness benefit days” (as described earlier under “Occasional illness days”), those days will be used first to fund your STD benefit. This will not extend the length of approved STD time off. However, if you have any “sickness benefit days” remaining after your STD benefit of 100% pay is exhausted, you can use those days to remain at 100% pay (instead of 70% pay) as long as your medical condition would meet the standard for receiving STD pay. For example, suppose you had exhausted your occasional illness days for the year, had 60 “sickness benefit days” and became disabled for 14 weeks. During your one-week waiting period, you would use 5 sickness benefit days. After receiving STD benefits of 100% pay for eight weeks (using 40 sickness benefit days), you would use your remaining 15 days of sickness benefits to continue receiving 100% pay for three weeks. For the remaining two weeks of your disability, you would receive STD benefits at 70% pay.

Claiming your STD benefits

- In order to receive STD benefits, you must submit a request. As soon as you become aware of an illness or injury that may cause you to be unable to work for seven consecutive calendar days or more, notify your manager and call the Personnel Center to request the paperwork you need.
- You and your physician will be contacted and will be required to provide medical documentation to substantiate your disability. You may call the Personnel Center if you have general questions about STD.

Other important information

- Upon the request of STD administration, an independent panel of board-certified specialists will review your claim, or you may be required to have an independent medical exam (IME).
- STD administration has the final authority to evaluate a claim. It is possible that the claim may not be authorized or that it may be limited.
- If you return to work from a disability leave of absence, and then leave active service within 30 calendar days of the return to work for the same or related condition, the second leave will be considered a continuation of the same disability.
- If you become disabled during the paid portion of a maternity, paternity or adoption leave, you can be eligible to switch to an STD leave. STD benefits would be available beginning on the eighth day of your disability. In order to qualify, you must notify your manager and the Personnel Center immediately upon becoming disabled and submit medical evidence, and be approved as eligible for the STD benefits by STD administration.
- Any STD benefits you receive, but for which the company determines you are not eligible, will be considered a pay advance. Therefore, this amount may be reconciled from your pay, or otherwise recovered from you, to the extent permitted by law. If you leave the company, the amount may be reconciled from your final pay, or otherwise recovered from you, to the extent permitted by law.

Disabilities not covered by STD

The STD plan does not cover a disability that:

- Begins during the first 12 months of service
- Begins while you are on an unpaid leave of absence other than a medical leave
- Begins after you have been displaced (officially notified in writing of eligibility) under the corporate severance program
- Begins while you are in a job search period (paid or unpaid)
- Is not approved as eligible by STD administration.

Long-term disability (LTD)

The long-term disability plan provides financial protection if you suffer an extended disability. If illness, injury or pregnancy disables you for more than 26 consecutive weeks, you may be eligible for long-term disability benefits.

Coverage options

The amount that you pay for LTD coverage depends on your age, the level of coverage you elect, and whether you are a full- or part-time associate.

If your annual base pay rate changes during the year, your LTD coverage amount and the premium charged will be adjusted accordingly. If you are not actively at work the date your pay rate changes, the new monthly benefit amount will take effect on the date you are again actively at work.

The actual benefit you would receive if you become disabled and qualify for LTD payments is described later in this section, under “Monthly LTD benefits.”

Full-time associates

Bank of America provides full-time associates with a core level of LTD coverage equal to 50% of annual base pay at no cost to the associate. If you are a full-time associate, you may purchase supplemental coverage on a before-tax basis that will bring your total LTD coverage to either:

- 60% of annual base pay
- 60% of the sum of annual base pay and eligible bonus amount.

Part-time associates

Part-time associates may purchase LTD coverage on a before-tax basis equal to:

- 50% of annual base pay
- 60% of annual base pay
- 60% of the sum of annual base pay and eligible bonus amount.

If you are a part-time associate and are considering waiving LTD coverage, consider carefully the consequences of your decision. Long-term disability coverage provides you and your family important income replacement and protects against financial hardship if you become seriously ill or injured and cannot work.

In addition, under current policy, certain other benefits are based on your eligibility to receive LTD benefits.

Eligibility

Full-time and part-time associates are eligible for LTD coverage.

You must be actively at work the day that coverage becomes effective.

Actively at work means you are performing all material duties of your job in the location where these duties are normally carried out. If you are not actively at work on the date coverage would become effective, then coverage becomes effective on the date you return to active work.

Waiting period

Benefits are payable after 26 consecutive weeks of disability as determined by the insurance company. The plan allows for a temporary cessation of disability as an incentive for an associate to return to work after a disability. If you return to work during the waiting period, but subsequently go back on disability after fewer than 31 calendar days of work, you are not required to satisfy a new 26-week waiting period. Any days of active work during the waiting period do not count toward satisfying the waiting period.

Important note: This limited interruption provision does not apply if you become eligible for any other group LTD benefits during the waiting period.

Disability determination

The existence of a disability is determined by the insurance company, based on medical evidence acceptable to it. To be considered disabled under the plan, you must meet the following requirements:

- Due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment from a doctor on a continuing basis unless, in the opinion of a doctor, future or continued treatment would be of no benefit
- and
- During the first 24 months, including your LTD waiting period, you are unable to earn more than 80% of your predisability earnings or indexed predisability earnings at your own occupation for any employer in your local economy.
- After the first 24-month period, you are unable to earn more than 60% of your indexed predisability earnings from any employer in your local economy at any gainful occupation for which you are reasonably qualified, taking into account your training, education, experience and predisability earnings.

LTD benefits are payable for a pregnancy-related disability like any other disability. Additional limitations apply if the disability results from a mental or nervous disorder, or alcohol or drug abuse. These rules are discussed later in this section.

Health and wellness

Illness, injury and disability benefits

Pre-existing condition limitation

Any disability that is caused by, contributed to, or results from a pre-existing condition is not covered. A pre-existing condition is one for which you received medical treatment or consultation, medical care or services, diagnostic tests, or prescription drugs or medicines during the three months immediately before your effective date for LTD coverage. This limitation does not apply to a disability that begins after you have been actively at work for 12 months following your effective date of coverage.

If you elect coverage at annual enrollment that is higher than your coverage the previous year and you apply for LTD benefits for a pre-existing condition that existed within the 12 months before the date the increased coverage would become effective, your benefit is based on the level of coverage in effect the previous year. If you did not have coverage during the previous year, you may elect coverage, but your pre-existing disability will not be covered.

Example: Suppose for plan year 2005 you are covered under the 50%-of-pay option. In 2005, you receive treatment for a medical condition. During annual enrollment for plan year 2006, you elect the 60%-of-pay-plus-bonus option. Beginning February 1, 2006, you can no longer work because of that medical condition. Your LTD benefit will be based on the 50%-of-pay option.

Mental illness and alcohol or drug abuse

If your disability is due to a mental, emotional or nervous condition of any kind, or if your disability is caused or contributed to by drug or alcohol abuse, your benefit payments are limited to 24 months, unless you are confined to a hospital. For benefits to continue beyond 24 months, you must be continuously confined to a hospital, subject to the maximum benefit duration described later in this section.

Recurrence of disability

If an associate who has been disabled and receiving benefits resumes his or her regular job on a full-time basis **for less than six months** and becomes disabled again from the same or a related cause, that disability is considered a continuation of the former disability. A new waiting period does not have to be satisfied. If at any time an associate becomes eligible for coverage through any other group LTD policy, this recurrent disability provision does not apply.

If an associate who has been disabled and receiving benefits resumes his or her regular job on a full-time basis **for six months or more** and becomes disabled again from the same or a related cause, that disability is considered a new one and a new waiting period must be completed before monthly benefits can begin.

Rehabilitation program

While disabled, your monthly benefit before reduction of other income benefits is increased by 10% when you participate in a rehabilitation program approved by the insurance company.

Early intervention is critical to your recovery and return to work. If your disability will be extended, you may be eligible for assistance from a qualified vocational rehabilitation consultant through the LTD insurance carrier (MetLife) during the 26-week waiting period. The Personnel Center can connect you with the insurance carrier. If you begin receiving LTD benefits, the insurance company carefully reviews every LTD claim for possible rehabilitation employment. Both Bank of America and the insurance company will work with you and your doctor to develop an effective rehabilitation program to return you to productive employment.

Filing a claim

On or around the 17th week after your STD benefits or medical leave begins, a case manager from MetLife should contact you to begin collecting the appropriate information to assess whether or not you are eligible for LTD benefits. The case manager may ask you to provide additional information, such as medical documentation. If your claim is approved, your transition from STD to LTD will occur without a disruption of benefits, if applicable.

Evidence of disability

You must give the insurance company written evidence of disability under the long-term disability plan within three months after the end of the waiting period.

Unless you do not have the legal capacity, you may furnish such proof up to one year after the time the insurance company required it, but late proof may be accepted only if it is furnished as soon as reasonably possible.

You must furnish written evidence of the continuance of the disability to the insurance company at its request.

The insurance company, at its own expense, has the right and opportunity to examine any associate whose injury or disease is the basis of a claim when and as often as it may reasonably require during the period for which that associate claims benefits.

Evidence of other income

If you are eligible for other sources of income, you must state the amount of those other income benefits and provide proof, satisfactory to the insurance company:

- That you have applied or reapplied for these other sources of income
- That you have not subsequently waived or transferred these other income benefits.

The insurance company has the right to require satisfactory proof of your monthly income. Such proof may include examination of your business and personal financial records. Your financial records may be examined as often as the insurance company requires.

If satisfactory documentation is not provided within 60 days after the date it is requested, the insurance company may deny your claim.

You cannot bring any action at law or in equity to recover on any group policy after three years from the time written proof is required.

Monthly LTD benefits

If your claim is approved, your monthly long-term disability benefit depends on which of the following coverage options is in effect when you become disabled:

- 50% of your monthly pay
- 60% of your monthly pay
- 60% of the sum of your monthly pay and $\frac{1}{2}$ of your eligible bonus amount.

If you are salaried, your monthly pay is equal to $\frac{1}{2}$ of your annual salary on the day you become disabled. If you are not salaried, your monthly pay is equal to your pay for your weekly projected average hours (entered as scheduled hours on the payroll system), multiplied by 52 and then divided by 12. If you are a commissioned associate, your monthly pay will reflect your draw and/or salary, plus 100% of commissions, averaged for the 12 full calendar months preceding the date your disability began, or from the date of employment, if less than 12 months.

Your eligible bonus amount is defined in the "Benefits overview" chapter earlier in this handbook. Your eligible bonus amount for purposes of determining your LTD benefits is listed in your annual enrollment materials for the year your disability began.

Example: Suppose you become disabled on September 1, 2005. You are eligible for LTD benefits after 26 weeks of disability, so the first day you are eligible to receive LTD benefits is the 183rd day after your disability began, or March 2, 2006. For 2005, you elected LTD coverage of 60% pay plus eligible bonus. Your monthly LTD benefit is based on:

- Your monthly rate of pay on September 1, 2005, plus
- $\frac{1}{2}$ of your eligible bonus amount for 2005 coverage (the year disability commenced), which is shown on the annual enrollment materials you received in fall 2004.

Your monthly long-term disability benefit will be reduced by certain other income sources as described below. The maximum monthly long-term disability benefit for 2005 is \$30,000 before any reduction for other income sources.

If you selected either 60% of pay or 60% of the sum of pay and eligible bonus, the minimum monthly benefit will not be less than 10% of the monthly benefit before reduction for other income sources, or \$100, whichever is greater. However, if you are already receiving 100% of salary through an accumulated sick leave plan, the minimum monthly benefit will not be payable.

Your monthly benefit will be reduced by 50% of your earnings from working while disabled. In addition, during any period of disability, the total of the monthly benefit, plus any income earned while disabled, cannot exceed 100% of your "indexed predisability monthly earnings." In either of these cases, the minimum monthly benefit will not apply.

Health and wellness

Illness, injury and disability benefits

Income sources that reduce LTD benefits

The following income sources reduce long-term disability benefits:

- Social Security disability or retirement benefits, not including future increases because of cost-of-living adjustments. (These benefits include your own and any family or dependent benefits for which you or your family is eligible that are payable on account of your disability.)
- Any amounts you receive or are eligible for under Workers' Compensation law, occupational disease law, or any other similar law
- Sick pay and other salary continuation, other than vacation pay, paid to you by Bank of America
- Any other disability income from Bank of America for which you are eligible
- Disability, retirement or unemployment benefits required or provided for by any law or government, such as state disability insurance payments.

If you are awarded back payments from other sources of income, including Social Security disability benefits, and these are not taken into account in calculating benefits payable through this plan, you must reimburse the plan for the amount of overpayment.

Estimating Social Security benefits

The LTD plan reserves the right to reduce an associate's monthly benefit by estimating Social Security benefits. However, if during your 26-week waiting period (before LTD benefits are payable), the plan receives proof that you have applied for Social Security benefits, and you have signed an Agreement Concerning Long-Term Disability Benefits, benefits will not be reduced by estimated Social Security benefits for the first 24 months of LTD payments.

By signing an Agreement Concerning Long-Term Disability Benefits:

- You agree to repay all benefit overpayments to the plan.
- You authorize the plan to obtain information on applications, denials and awards directly from the Social Security Administration.

If you have not received approval or final denial of your claim from the Social Security Administration by the end of this 24-month period, the plan will begin reducing your monthly benefit by an estimate of the Social Security benefits. Final denial of your claim means that you have received a Notice of Denial of Benefits from an administrative law judge.

When you receive approval or final denial of your claim from the Social Security Administration:

- Your monthly benefit will be adjusted.
- You must promptly refund to the plan an amount equal to all overpayments. If you do not promptly make such refund, the plan may reduce or offset against any future benefits payable.

How benefits are paid

Benefits under the long-term disability plan begin after the 26-week waiting period has ended. The LTD benefit payment is based on the number of days you are disabled during each one-month period.

If you receive an overpayment of LTD benefits, the insurance company has the right to recover such overpayment, either directly from you or by deduction from your future monthly income benefit payment.

When LTD payments end

Your disability benefits end when any one of the following occurs:

- You cease to be disabled.
- After 24 months of benefit payments, if your disability is due to a mental, emotional or nervous condition of any kind or caused or contributed to by drug or alcohol abuse, you are not continuously confined to a hospital.
- After 24 months of benefit payments, you are able to perform the material duties of any gainful work or service for which you are reasonably qualified, taking into consideration your training, education, experience and past earnings, and you are able to earn more than 60% of your indexed predisability earnings.
- You begin working at any gainful work or service during the first 24 months of benefit payments and earning more than 80% of your indexed predisability monthly earnings. Work in a rehabilitation program approved by the insurance company is excluded.
- You cease to be under the regular care of a physician (unless, in the opinion of a physician, future or continued treatment would be of no benefit and you continue to meet this plan's definition of disability).
- You fail to furnish the required proof of the continuance of your disability to the insurance company, or you refuse to be examined by a physician designated by the insurance company at the insurance company's expense.
- You reach the maximum benefit duration as described later in this section.
- You die.

If you become disabled before age 60 and you remain disabled, your benefits will cease at either your Social Security normal retirement age or the end of the calendar month in which you reach age 65, whichever is later.

If you become disabled on or after the date you reach age 60 and you remain disabled, the maximum number of months benefits are payable is the greater of:

- The benefit duration shown in **Figure 3.6**
- The months until your Social Security normal retirement age.

Disabilities not covered by the LTD plan

You are not covered for any disability that results from or is caused or contributed to by any of the following:

- War, insurrection or rebellion
- Active participation in a riot
- Intentionally self-inflicted injuries or attempted suicide
- The commission of a felony.

When LTD coverage ends

Your coverage under the plan ends:

- The date your employment ends
- When you cease to be a full- or part-time associate or otherwise become ineligible for the plan
- When you go on an unpaid leave of absence other than a medical leave
- When you have been displaced (officially notified in writing of eligibility) under the corporate severance program
- If the plan ends.

If you are a full-time associate enrolled in the 60%-of-pay option or the 60%-of-pay-plus-bonus option and you fail to pay the associate portion of your premiums for 30 days, your coverage will be reduced to the 50%-of-pay option. This reduction is effective retroactively as of the end of the last pay period for which you paid for coverage.

If you are a part-time associate and you fail to pay the associate portion of your premiums for 30 days, your coverage will be terminated retroactively effective as of the end of the pay period for which you paid for coverage.

If you are absent from active work because of a paid leave or an unpaid medical leave, LTD coverage can continue for a maximum of six months (combined paid and unpaid portions of all leaves), provided you pay any applicable premiums.

If you become disabled before your coverage terminates, you are still eligible to apply for and receive long-term disability benefits as long as they would otherwise be available under the plan.

Workers' Compensation

This insurance provides for payment of authorized medical treatment in accordance with the Workers' Compensation laws of your state, for a work-related accident, injury or illness. Workers' Compensation also provides you with partial wage replacement while disabled as a result of a work-related accident, injury or illness.

The cost of your Workers' Compensation benefits is completely paid for by Bank of America.

Workers' Compensation laws vary from state to state. Each state sets its own limits on benefits. The following guidelines provide a general overview of the process and how Workers' Compensation works in coordination with your occasional illness, STD and LTD benefits.

3

Figure 3.6

LTD benefits duration	
Age when disability begins	Benefit duration in months
60	60
61	48
62	42
63	36
64	30
65	24
66	21
67	18
68	15
69 and over	12

Health and wellness

Illness, injury and disability benefits

Procedures for reporting your Workers' Compensation claim

If you are injured at work or experience a work-related illness, no matter how minor the injury may seem, you must report it immediately to your manager or someone in a managerial capacity.

Your manager or supervisor must call the Personnel Center within 24 hours and speak with a Bank of America Workers' Compensation Claim Analyst and answer certain questions needed to set up your claim. For Washington State, managers must call Intermountain Claims at **1.800.372.7678**. The claim information will be transferred to our insurance company. You or your manager may be contacted by the insurance adjuster handling your claim. In some circumstances, you may be contacted by a Bank of America Claim Analyst to explain to you the Workers' Compensation process and what to expect during the handling of your claim.

Payment of benefits

- The associate must report the Worker's Compensation leave of absence to the manager/supervisor.
- The associate must initiate the Worker's Compensation leave of absence by calling the Personnel Center and following all voice-activated prompts.
- Workers' Compensation benefits are always considered primary to other benefits; occasional illness days, STD, LTD, state disability insurance (SDI) and Social Security benefits are considered secondary and are reduced by Workers' Compensation benefits where applicable.
- Compensation from all sources is never more than 100% of your base pay.
- Workers' Compensation pays all authorized medical treatment and begins wage replacement upon completion of the state mandated waiting period.

- You may use your available illness, vacation or purchased time off days to help fund the unpaid, state-mandated waiting period.
- If the claim is accepted, the insurance company will retroactively pay you for those days taken during the state-mandated waiting period.
- Other sources of income may be calculated to determine the appropriate amount of Workers' Compensation benefits.
- The insurance company has the right to examine payroll and personnel records to ensure satisfactory proof of your monthly income as often as it requires.

Long-term care insurance

The long-term care insurance plan is provided under a group insurance contract underwritten by John Hancock Life Insurance Company (John Hancock), Boston, MA 02117.

Long-term care insurance provides coverage that helps protect you and covered family members against the costs for care associated with an extended illness, a serious injury or aging. You, your spouse, parents and parents-in-law are eligible to apply for this benefit. Your domestic partner and your domestic partner's parents are eligible in most states. Contact the John Hancock Long-Term Care Customer Service Center at **1.800.582.2632** for details. Individuals (other than yourself) must be at least age 18 in order to be enrolled.

The plan provides important financial protection by helping to pay for care needed for an extended period — months or even years.

The insurance pays benefits for the cost of covered services up to a specified dollar amount per day, up to a maximum lifetime limit for all covered charges incurred while you are insured. These limits depend on the option you select.

The plan provides coverage for care that is generally not covered under the company-sponsored medical plans or Medicare. The following types of care are typically covered, if provided by a qualified caregiver:

- Nursing home care
- Alternate-care facility care
- Home health care
- Adult day care
- Informal care.

Qualifying for benefits

You qualify for benefits when a John Hancock patient advocate certifies that, because of a covered condition, you are dependent in at least two of six significant activities of daily living (SADL) or you are cognitively impaired, and you have completed the qualification period.

You are dependent in a significant activity of daily living if you need substantial assistance from another person to perform a SADL because of a loss of functional capacity that is expected to continue for at least 90 days.

The six SADLs are:

- Bathing
- Dressing
- Eating
- Maintaining continence
- Toileting
- Transferring from bed to chair.

The patient advocate considers your cognitive and physical ability to perform these activities independently and appropriately without supervision or help from another person. For example, if you can't bathe or eat without substantial assistance from another person, and that assistance is expected to be needed for at least 90 days, you will be considered dependent in these activities.

You are cognitively impaired if you have a deterioration or loss of intellectual capacity because of an organic brain disorder that requires you to need substantial supervision for the protection of yourself or others.

The qualification period is the time you must wait after you become certified for benefits, during which no benefits are payable for covered charges you incur. The qualification period for this coverage is 60 days. You must remain certified during this period, but you don't have to be hospitalized or receive any covered services. The policy pays benefits for covered charges you incur after the qualification period is met, as long as you remain certified.

Enrollment

Newly hired full- and part-time associates may enroll in the long-term care insurance plan within 31 days of first becoming eligible for company benefits without providing evidence of good health. Associates who enroll or increase their coverage level in the long-term care insurance plan after their initial enrollment period must provide evidence of good health acceptable to the insurance carrier, John Hancock Life Insurance Company.

All other eligible persons who enroll or increase their level of coverage in the long-term care insurance plan are required to provide evidence of good health acceptable to the insurance carrier.

If you, your spouse or domestic partner, your parents or parents-in-law, including parents of domestic partners, have questions or want to receive more information about long-term care, contact John Hancock directly by calling the Long-Term Care Customer Service Center at **1.800.582.2632**.

Because rates and coverage amounts are individually calculated, you can request long-term care insurance enrollment and rate information at any time during the year through the Personnel Center or directly from John Hancock. Rates vary by the issue age of the applicant, state of residence and actual plan features you choose. If you want to enroll, you will be sent detailed enrollment materials, which will include policy limitations and exclusions. The insurance carrier must approve your application before coverage is effective. You can enroll, cancel or decrease coverage at any time during the plan year.

You must be actively at work the day that coverage becomes effective.

Actively at work means you are performing all material duties of your job on a regular basis in the location where these duties are normally carried out. If you are not actively at work on the date coverage would become effective, then coverage does not become effective until the first day of the month following the date you are again actively at work.

Certificate of insurance

The certificate of insurance you receive once you are approved for coverage describes your coverage and the exclusions for your state of residence. If you move to another state, the state guidelines outlined in the certificate of insurance originally issued to you continue to apply.

Health and wellness

Life Insurance



Life insurance

Overview

Bank of America offers the following group insurance plans to full-time and part-time associates for financial protection in the event of death or serious accidental injury:

- Associate basic life insurance
- Associate supplemental life insurance
- Accidental death and dismemberment (AD&D) insurance
- Dependent life insurance (spouse/domestic partner and dependent child life insurance).

Full-time, part-time and hourly associates are automatically covered by business travel accident insurance.

When coverage ends

Effective April 1, 2005, if your employment ends for reasons other than retirement, coverage generally ends on the last day of the pay period in which your last day of employment occurs, provided you have paid for coverage for that period.

If you retire, your coverage as an associate ends at the end of the month in which your last day of employment occurs. However, in 2005, coverage for legacy Fleet associates who are retiring ends at the end of the pay period in which the last day of employment occurs. You may be eligible for retiree life insurance. See the section "When you retire" later in this handbook.

In other situations, coverage generally ends on the last day of the month in which one of the events listed below occurs, provided that you have paid for coverage for that month. If the event occurs on the first day of the month, coverage ends the last day of the previous month. Coverage ends if:

- You change from a full- or part-time position to an hourly position.

- You cancel your coverage (restrictions apply).
- Bank of America ceases to offer group life insurance.
- You're on a non-medical paid or unpaid leave of absence for more than 26 weeks.
- You're on a paid or unpaid medical leave of absence for more than 24 months.

Your coverage will also end if you do not pay the associate portion of your premiums for 30 days. If this occurs, your coverage will be canceled retroactively as of the end of the last period for which you had paid for coverage.

Business travel accident insurance ends on your last day of employment.

When your coverage ends, associate life insurance and spouse/domestic partner life insurance generally may be converted to an individual policy or continued under portable term group coverage. Dependent child life insurance generally may be converted to an individual policy (but cannot be continued under portable term group coverage). Conversion and continuation options are not available for AD&D or business travel accident insurance.

Associate life insurance

Life insurance is designed to protect the future of those who depend on your income for support.

Associate basic life insurance

Bank of America provides eligible associates with associate basic life insurance equal to one times annual base pay (rounded up to the next \$1,000), up to a maximum of \$2 million, at no cost to the associate.

Generally, you must be actively at work the day that coverage becomes effective. *Actively at work* means you are performing all material duties of your job in the location where these duties are normally carried out. If you are not actively at work on the date coverage would become effective, coverage becomes effective on the date you return to active work.

If your annual base pay rate changes during the year, your basic life insurance coverage amount will be adjusted accordingly.

You are required to pay imputed income tax on the value of any company-paid life insurance in excess of \$50,000. See the “Imputed income” section in the “Benefits overview” chapter of this handbook for more information. If your annual base pay exceeds \$50,000, you will have the option to limit your basic life insurance coverage to \$50,000.

You may also purchase additional supplemental life insurance coverage (see the “Associate supplemental life insurance” section below).

Associate supplemental life insurance

You may purchase associate supplemental life insurance on an after-tax basis in the following amounts (rounded up to the next \$1,000), up to a maximum of \$3 million:

- One times the sum of your annual base pay plus eligible bonus
- Two times the sum of your annual base pay plus eligible bonus
- Three times the sum of your annual base pay plus eligible bonus
- Four times the sum of your annual base pay plus eligible bonus
- Five times the sum of your annual base pay plus eligible bonus
- Six times the sum of your annual base pay plus eligible bonus
- Seven times the sum of your annual base pay plus eligible bonus
- Eight times the sum of your annual base pay plus eligible bonus.

Your annual base pay and eligible bonus amount are defined in the “Benefits overview” chapter. If your annual base pay rate changes during the year, your supplemental life insurance coverage amount and the premium charged will be adjusted accordingly.

The cost of your premium depends on the amount of coverage you choose, your age as of December 31 of the coverage year, and your tobacco user status (if you do not use tobacco products, your premium will be lower).

Enrollment

When you first become eligible to enroll in supplemental life insurance (i.e., as a newly hired associate, or if you switch from hourly to full- or part-time status), you may elect coverage up to three times your annual base pay and eligible bonus, to a maximum of \$500,000, without providing evidence of good health, if you enroll within 31 days of becoming eligible. If you elect coverage that is greater than three times your annual base pay and eligible bonus, or if you elect coverage that exceeds \$500,000, you must provide evidence of good health that is satisfactory to the insurance company.

During future annual enrollment periods or when you have a qualifying event (as described in the “Benefits overview” chapter), if you elect coverage for the first time, increase coverage, or elect coverage over \$500,000, you must provide evidence of good health.

If evidence of good health is required, the increased coverage does not begin until after your evidence of good health is approved by the insurance company. If you fail to provide evidence of good health when required, you will be assigned the highest coverage available without evidence of good health.

Health and wellness

Life Insurance

You generally must be actively at work the day that coverage becomes effective. *Actively at work* means you are performing all material duties of your job in the location where these duties are normally carried out. If you are not actively at work on the date coverage would become effective, coverage becomes effective on the date you return to active work.

Beneficiary

Any life insurance amount payable as a result of your death is payable to the persons designated by you as your beneficiaries on the Bank of America beneficiary form. You may designate separate beneficiaries for associate basic life insurance and associate supplemental life insurance. In most cases, you may, without the consent of your beneficiaries, change your designations by filing a new beneficiary form on Personnel Online. The new designation(s) takes effect on the date the completed form is received by the Personnel Center.

If you designate more than one beneficiary but fail to specify their respective interests, the beneficiaries will share equally. Unless otherwise provided in your beneficiary designation, the interest of any designated beneficiary who dies before you will terminate, and that beneficiary's interest will be shared equally by any beneficiaries who survive you. If you die and no beneficiary designation is in effect for any part of the insurance, or if there is no surviving designated beneficiary, the benefits will be paid pursuant to the policy.

It may be possible to assign your associate basic life insurance and associate supplemental life insurance (for example, to certain relatives or trusts), if specifically permitted under the terms of the policy. Contact the Personnel Center for information.

Submitting claims

When the insurance company receives a certified copy of your death certificate and any other information or forms it may request in connection with the claim, the amount of your associate life insurance is paid to your beneficiary in one lump sum, unless your beneficiary arranges with the insurance company to receive installment payments. If you or your beneficiary has questions about claim procedures, call the Personnel Center.

Accelerated death benefit

The life insurance plan has an accelerated death benefit available, under which associates may request accelerated payment of their associate life insurance benefits. This provision is available for an associate who is diagnosed with a terminal illness and has a life expectancy of six months or less. The insurance company requires medical evidence that it deems acceptable before approving a payment under the accelerated death benefit provision.

If an associate receives an accelerated benefit payment, it may affect the individual's eligibility for a state or federal benefits program, such as Medicare. Also, the accelerated benefit may be subject to taxes. An associate should consult with a tax adviser before making a decision. The Personnel Center handles requests for accelerated death benefits.

The minimum amount payable as an accelerated death benefit is \$5,000. The maximum amount payable is 50% of an associate's annual base pay but not more than \$250,000. The insurance providers charge a \$150 fee for administering an accelerated death benefit, which will be deducted from the accelerated benefit payment. Payment of accelerated benefits will reduce your life insurance benefit and the amount available for conversion to an individual policy.

Accelerated death benefits will not be payable for any amount of life insurance you have previously assigned, or if you are applying for an accelerated death benefit due to attempted suicide, injuring yourself on purpose, alcohol or drug abuse, a war or warlike action, or any event occurring while you are in violation of criminal law.

Conversion to an individual policy

You may convert to an individual life insurance policy any portion of your associate life insurance that is terminated because your employment ends or you are no longer a full- or part-time associate. Evidence of good health is not required to obtain the individual policy. The amount of the individual policy may not exceed the amount of life insurance held immediately before the termination of your coverage under the associate life group policy.

If you wish to apply for the individual policy, you must contact the Personnel Center to initiate the process. You have 31 days following the termination of your group associate life coverage to submit your completed conversion application to the insurer. The individual policy may be any form of life insurance, other than term insurance or insurance containing disability or other supplementary benefits that is customarily issued by the insurance company at the age and amount for which you paid. The premiums will be based on your age, class of risk, the type of insurance you choose and the amount of the individual policy.

If the associate life insurance group policy is terminated or amended so as to terminate your coverage and if, at the date of termination, you have been insured under the provisions of any rider or any group policy replaced by this group policy for at least five years prior to the termination date, you may convert such coverage to an individual policy, subject to the same conditions described in the preceding paragraph. The amount of the individual policy may not exceed the lesser of:

- The amount of your life insurance immediately before the termination of your group coverage, reduced by any group life insurance for which you become eligible within the following 31 days
- \$10,000.

If you apply, the individual policy becomes effective 31 days after your group associate life coverage ends. If you die within 31 days after your group associate life coverage ends, the insurance company pays to your beneficiary (or beneficiaries) an amount equal to the amount to which you could have converted, regardless of whether you had applied for an individual policy.

The beneficiary (or beneficiaries) is paid only on the receipt of a certified copy of your death certificate and any other information and forms requested by the insurance company in connection with the claim. Any beneficiary you designate under the individual policy who is someone other than the beneficiary you designate under the group policy is considered a notice of change of beneficiary.

Portable term group coverage

Instead of converting to an individual policy when any portion of your associate life insurance is terminated because your employment ends or you are no longer a full- or part-time associate, you may continue your associate supplemental life insurance under portable term group coverage. Evidence of good health is not required.

You are eligible for the portability option if your associate life insurance ends because your employment ends or you are no longer a full- or part-time associate. You may choose either portability or conversion for your associate supplemental life insurance. Any amount of supplemental associate life insurance that you do not continue under the portability option may be converted to an individual policy.

If you are eligible for retiree life insurance, the amount of coverage eligible for conversion/portability is reduced by the amount of retiree life insurance for which you are eligible.

For example:

- Lee has a salary of \$35,000 (with no annual bonus).
- Lee has company-paid associate basic life insurance coverage of one times pay (\$35,000) and associate supplemental life insurance coverage in the amount of five times annual base pay (\$175,000), for total coverage of \$210,000.
- When Lee's employment ends, associate basic and supplemental life insurance coverage ends. If Lee wants to take advantage of the portability option, Lee can elect to continue any amount of the associate supplemental life insurance up to \$175,000 under portable term group coverage. (Lee can also convert any amount of the basic associate life insurance up to \$35,000 to an individual policy, but this is not required in order to continue associate supplemental life insurance).

The amount of coverage you can continue under the portability option cannot exceed the amount of associate supplemental life insurance that is terminating under the Bank of America plan. The minimum amount of coverage an associate can port is \$20,000, and the maximum is up to the amount of associate supplemental life insurance coverage terminating or \$1 million, whichever is less. Michigan residents may be limited in the amount of coverage eligible for portability. The portability option is not available to residents of Oregon, South Dakota and Vermont.

In order to continue coverage, the insurance carrier must receive your completed portability request form within 31 days following the termination of your group associate life insurance coverage, or within 45 days from the date you receive the portability and conversion notice, but in no event more than 90 days following the termination of your group associate life insurance coverage.

Health and wellness

Life Insurance

If a request to continue coverage is made and the first premium is made in a timely manner, the insurance carrier will issue you a new certificate of insurance that explains the new insurance benefits. The insurance benefits under the new certificate may not be the same as those under the Bank of America plan. Premiums will be paid directly to the insurance carrier. A schedule of premiums and payment instructions will be provided at the time the new certificate is issued.

If you die within 31 days after your group associate life insurance ends, in general the insurance carrier pays your beneficiary (or beneficiaries) in accordance with the information in the "Conversion to an individual policy" section. However, if you applied to continue coverage and your portability request form was received by the insurance carrier during this 31-day time period, associate supplemental life insurance benefits will be paid according to the amount of associate supplemental life insurance you had applied to continue under the portability option.

Accidental death and dismemberment (AD&D) insurance

Accidental death and dismemberment (AD&D) insurance provides benefits if you or a covered dependent suffer a loss of life, limb, sight, speech or hearing or become paralyzed as a result of a covered accidental injury. For purposes of the policy, *injury* means a bodily injury effected solely through external violent and purely accidental means.

AD&D insurance premiums are paid on a before-tax basis.

Enrollment

No evidence of insurability is required. You may change your coverage level during annual enrollment.

Associates can choose any one of the following coverage amounts for themselves, up to a maximum of \$3 million:

- No coverage
- One times the sum of annual base pay plus eligible bonus
- Two times the sum of annual base pay plus eligible bonus
- Three times the sum of annual base pay plus eligible bonus
- Four times the sum of annual base pay plus eligible bonus
- Five times the sum of annual base pay plus eligible bonus
- Six times the sum of annual base pay plus eligible bonus
- Seven times the sum of annual base pay plus eligible bonus
- Eight times the sum of annual base pay plus eligible bonus.

You also may choose to cover your family. Domestic partners are eligible for AD&D coverage in most states; contact the Personnel Center for details.

If you elect family AD&D insurance:

- Your spouse or domestic partner will be covered for 60% of your coverage amount, up to a maximum of \$600,000.
- Each eligible child will be covered for 20% of your coverage amount, up to a maximum of \$50,000.

Accidental death and dismemberment (AD&D) benefits

The coverage amount you purchase is called the principal sum. The amounts payable for specified losses from bodily injury caused by an accident occurring while the coverage is in force, and causing loss within one year of the accident, are:

- The principal sum for loss of:
 - Life
 - Both hands or both feet
 - Sight of both eyes
 - One hand and one foot
 - One hand or foot and sight in one eye
 - Speech and hearing
- One half the principal sum for loss of:
 - One hand or foot
 - Sight in one eye
 - Speech or hearing
- One fourth the principal sum for loss of:
 - Thumb and index finger of same hand.

Loss means:

- Hands and feet — complete severance through or above the wrist, but below the elbow, or ankle joint, but below the knee
- Eyes — total and irrecoverable loss of sight
- Thumb and index finger — permanent severance through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb
- Speech — total and irrecoverable loss that continues for six months following the accidental injury
- Hearing — total and irrecoverable loss in both ears that continues for six months following the accidental injury.

In some states, different definitions may be applicable. If a single accident results in more than one covered loss, only the loss with the largest amount payable will be paid. However, if you select family coverage and both you and your spouse or domestic partner die from injuries from the same accident within 365 days of each other,

the principal sum payable for the death of your spouse or domestic partner will be increased to equal that amount payable for your death.

This benefit provides coverage for accidental injury that results in the insured person losing the use of an arm or leg. This means there is paralysis (loss of use) of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible. For this type of covered loss, the plan pays a specified percentage of the Accidental Death & Dismemberment (AD&D) benefit amount as outlined in the AD&D policy.

Accidental death and dismemberment insurance may provide additional benefits if a covered accident involves one of the following:

- Coma
- Passenger restraint and airbag
- Repatriation of remains.

Also, if you choose family coverage, an education benefit and a child care benefit may be payable if one or both parents die in a covered accident.

Exclusions

Benefits are not paid for losses that result directly or indirectly from the covered individual's:

- Disease, bodily or mental infirmity, or by medical or surgical treatment thereof
- Infection (except for septic infections that occur through an accidental wound)
- Intentional, self-inflicted injuries or suicide, whether the individual is sane or insane
- Any act of war
- Full-time military duty
- Test, stunt or experimental flying
- Operating, learning to operate or serving as a crew member on an aircraft
- Use of alcohol, drugs or intoxicants, except as prescribed by a physician
- Voluntary inhalation of poisonous gases

- Commission of, or attempt to commit, a criminal act.

Beneficiary

Your beneficiary for loss of life benefits under the AD&D plan is the same as your associate basic life insurance beneficiary, unless you designate a different beneficiary for the AD&D plan. You may change your beneficiary at any time through Personnel Online or by contacting the Personnel Center at **1.800.556.6044**. If you die without a surviving designated beneficiary, benefits will be paid pursuant to the AD&D policy. If you choose family coverage, you automatically will be the beneficiary for your spouse or domestic partner and/or eligible children.

Submitting claims

If an associate or a covered member of an associate's family dies or suffers a loss in an accident, the Personnel Center should be contacted as soon as possible. A representative can assist you or your beneficiary in filing a claim with the insurance company. When the insurance company has received proof of loss acceptable to it, along with any other information or forms it may request with your or your beneficiary's claim, the AD&D benefit is payable to you or your beneficiary in one lump sum.

Dependent life insurance

Dependent life insurance assists you with the additional expenses you might have if your spouse, domestic partner or eligible dependent child dies. You need to decide whether you want this coverage and, if you do, which coverage level is right for you. Dependent life insurance premiums are paid on an after-tax basis.

Spouse/domestic partner life insurance

You may purchase life insurance for your spouse or domestic partner. The

following coverage options are available:

- No coverage
- \$10,000
- \$25,000
- \$50,000
- \$75,000
- \$100,000.

See the "Benefits overview" chapter for eligibility rules.

When you first become eligible to purchase spouse/domestic partner insurance (e.g., as a newly hired associate, if you switch from hourly to full- or part-time status, or when you first acquire your spouse or domestic partner), you may elect coverage up to \$50,000, without providing evidence of good health, if you enroll within 31 days of becoming eligible. If you elect coverage that exceed \$50,000, you must provide evidence of good health that is satisfactory to the insurance company.

During future annual enrollment periods, if you elect coverage for the first time, increase coverage by more than one level or elect coverage over \$50,000, your spouse or domestic partner must provide evidence of good health.

If evidence of good health is required, the increased coverage begins the first of the month following the date your evidence of good health is approved by the insurance company. If your spouse or domestic partner fails to provide evidence of good health when required, coverage defaults to the highest level that does not require evidence of good health. For example, if you get married, and you elect \$100,000 of coverage for your new spouse, he or she will be enrolled in the \$50,000 coverage level, if evidence of good health is not provided.

Health and wellness

Life Insurance

Dependent child life insurance

You may purchase life insurance for your eligible dependent children. The following coverage options are available:

- No coverage
- \$5,000 per child
- \$10,000 per child
- \$15,000 per child.

See the "Benefits overview" chapter for eligibility rules. In addition, to be eligible as a dependent for dependent life insurance purposes, a newborn child must be at least seven days old and have come home from the hospital.

No evidence of good health is required for dependent child life insurance.

Beneficiary

You are automatically the beneficiary of dependent life insurance. If your dependent dies at the same time your death occurs or within 24 hours of your death, the benefits will be paid pursuant to the policy.

Submitting claims

When the insurance company receives a certified copy of the death certificate of your dependent and any other information or forms it may request with the claim, the amount of dependent life insurance that you have purchased under the group policy is payable to you in one lump sum.

If you have questions about claims procedures, please contact the Personnel Center or call Fidelity at **1.800.556.6044** for legacy Bank of America associates and **1.888.737.7661** for legacy Fleet associates.

Conversion to an individual policy

You may convert to an individual policy any portion of your dependent life insurance that is terminated because your employment ends, you die, you are no longer in an eligible class that provides dependent life benefits, or the dependent is no longer an eligible dependent. Evidence of good health is not required to obtain the individual policy. The amount of the individual policy may not exceed the amount of life insurance held immediately before coverage termination under the dependent life group policy.

If you wish to apply for the individual policy, you must contact your dependent life insurance carrier within 31 days following the termination of the group dependent life coverage. The individual policy may be in life insurance, other than term insurance, which is customarily issued by the insurance company, and the premiums will be based on the dependent's age, class of risk, the type of insurance and the amount of the individual policy.

If the dependent life insurance group policy is terminated or amended to terminate your dependent coverage, and if, at the date of termination, your dependent has been covered under the group policy or any policy replaced by the group policy for at least five years prior to the termination date, you may convert such coverage to an individual policy. This option is subject to the same conditions described in the preceding paragraph. The amount of the individual policy may not exceed the lesser of:

- The amount of dependent life insurance immediately before your group coverage termination, reduced by any group life insurance for which your dependent becomes eligible within the following 31 days
- \$10,000.

If you apply, the individual policy becomes effective 31 days after your group dependent life coverage ends. If the dependent dies within 31 days after your group dependent life coverage ends, the insurance company will pay you an amount equal to the amount that could have been converted, regardless of whether you had applied for an individual policy. The payment of the death benefit will be in the same manner as if the dependent benefits had been in effect on the date of the dependent's death.

Portable term group coverage

Instead of converting to an individual policy, your spouse or domestic partner who was covered under your spouse/domestic partner life insurance may continue that coverage under portable term group coverage. Evidence of good health is not required. **Please note:** Dependent child life insurance cannot be continued under portable term group coverage.

Your spouse or domestic partner is eligible for the portability option if your dependent life insurance ends because your employment ends or you are no longer a full- or part-time associate, and you also elect portability for your associate supplemental life insurance coverage. In this case, the amount of dependent life insurance that is continued may not exceed the amount of associate supplemental life insurance that is continued. In addition, your spouse or domestic partner is eligible for the portability option if his or her coverage under your dependent life insurance ends because he or she ceases to qualify as your dependent (e.g., you die or you and your spouse divorce). Your spouse or domestic partner may choose either portability or conversion for dependent life insurance, but not both.

The amount of coverage eligible to continue under the portability option may not exceed the amount of spouse/domestic partner life insurance that is terminating under the Bank of America plan. The minimum amount of coverage that can be continued is \$10,000 and the maximum is up to the amount of spouse/domestic partner life insurance coverage terminating. The portability option is not available to residents of Oregon, South Dakota and Vermont.

In order to continue coverage, the insurance carrier must receive the completed portability request form within 31 days following the termination of your group dependent life insurance coverage, or within 45 days from the date you receive the portability and conversion notice, but in no event more than 90 days following the termination of your group dependent life insurance coverage.

If a request to continue coverage is made and the first premium is made in a timely manner, the insurance carrier will issue a new certificate of insurance that explains the new insurance benefits. The insurance benefits under the new certificate may not be the same as those under the Bank of America plan. Premiums will be paid directly to the insurance carrier. A schedule of premiums and payment instructions will be provided at the time the new certificate is issued.

If your spouse or domestic partner dies within 31 days after his or her coverage under your group dependent life insurance ends, in general the insurance carrier pays benefits in accordance with the information in the "Conversion to an individual policy" section. However, if an application to continue dependent life insurance was made and the portability

request form was received by the insurance carrier during this 31-day time period, dependent life insurance benefits will be paid according to the amount of dependent life insurance that was applied for continuation under the portability option.

Business travel accident insurance

Eligibility

All full-time, part-time and hourly associates of Bank of America are participants in this plan. No special enrollment is necessary. Eligible associates are covered from their first day of service.

Amount of coverage

You are covered for an amount equal to five times your annual base pay to a \$3 million maximum (\$2 million for a covered act of war) for accidental loss of life and a percentage of the loss of life benefit for loss of limb, sight, speech or hearing caused by accidental bodily injuries while traveling on business for Bank of America.

Description of coverage

Your coverage provides 24-hour coverage while traveling on assignment for or at the direction of Bank of America anywhere in the world (excluding everyday commuting and as noted under "Key exclusions"). Coverage begins at the actual start of a trip whether the point of origin is from your residence or regular place of employment, whichever occurs last. Coverage ends immediately upon return to your residence or regular place of employment, whichever occurs first.

You are also covered for losses resulting from accidental bodily injuries sustained as a result of a felonious assault or act of violence that occurs while you are on Bank of America premises.

Cost

The cost of this benefit is paid entirely by Bank of America.

Benefits

Benefit amount means the coverage amount as described under "Amount of coverage" that is applicable at the time of the accident. The loss must occur within one year of the accident.

The full benefit amount is payable for accidental loss of:

- Life
- Two or more members (hand or foot)
- Sight of both eyes
- Speech and hearing
- Any combination thereof.

One half the benefit amount is payable for accidental loss of:

- One member (hand or foot)
- Sight of one eye
- Speech or hearing.

One quarter of the benefit amount is payable for accidental loss of:

- Thumb and index finger of the same hand.

Fifteen percent of the benefit amount is payable for accidental loss of:

- Hearing in one ear
- A great toe.

Five percent of the benefit amount is payable for accidental loss of:

- A toe other than a great toe.

Loss means:

- With respect to a hand, complete severance through or above the knuckle joints of at least four fingers on the same hand*
- With respect to a foot, complete severance through or above the ankle joint*

*It is considered a loss of hand or foot even if the member is later reattached.

Health and wellness

Life Insurance

- With respect to hearing, permanent and irrecoverable loss of hearing in both ears
- With respect to speech, the permanent and irrecoverable total loss of the capability of speech without the aid of mechanical devices
- With respect to sight, permanent loss of vision; remaining vision must be no better than 20/200 using a corrective aid or device.

If you have multiple losses as a result of one accident, only the single largest benefit amount applicable to the losses suffered will be paid.

In the event of multiple accidental losses (to more than one covered individual) arising from any one accident, the total payment for all such losses will be limited to a maximum of \$20 million. Benefits will be proportionately divided among the insured up to the maximum limit of insurance.

Additional coverage

The plan also covers the following situations:

Rehabilitation benefit

If an accidental bodily injury causes an insured person to suffer a covered loss that results in a physician approved by the insurance company determining rehabilitation is required, the plan pays reasonable and customary charges incurred within two years from the date of the loss, up to 10% of the loss-of-life benefit amount.

Seat belt benefit

This benefit pays an additional 10% of the accidental loss-of-life benefit amount (up to a \$50,000 maximum), if, at the time of accidental death, the insured person was wearing a seat belt while operating or riding in a private passenger vehicle (excluding a race or contest of any kind).

Loss-of-use benefit

This benefit provides coverage for accidental injury that results in the insured person losing the use of an arm, leg, hand or foot. This means there is a permanent and total inability of the limb to function, as determined by a physician approved by the insurance company; there does not have to be actual severance of a limb. For this type of covered loss, the plan pays a specified percentage of the loss-of-life benefit amount as outlined in the business travel accident policy.

Medical evacuation and repatriation benefit

This benefit covers the cost of medical evacuation and repatriation associated with a covered loss (up to \$100,000) with travel assistance services provided by MEDEX Assistance Corporation.

Coma benefit

If an accidental bodily injury causes an insured person to lapse into a coma, the plan pays a monthly specified percentage of the loss-of-life benefit amount, subject to certain limitations, as outlined in the business travel accident policy.

Psychological therapy benefit

If an accidental bodily injury causes an insured person to suffer a covered loss that results in a physician approved by the insurance company determining psychological therapy is required, the plan pays reasonable and customary charges incurred within two years from the date of the loss, up to 10% of the loss-of-life benefit amount.

Key exclusions

You are not covered for any loss caused by or resulting from:

- Emotional trauma, mental or physical illness, disease or bodily malfunctions
- Pregnancy, childbirth or miscarriage
- Bacterial or viral infection (except bacterial infection caused by an accident or from accidental consumption of a substance contaminated by bacteria)
- Suicide or attempted suicide or intentionally self-inflicted injuries
- Use of an aircraft owned or leased by an associate, including yourself
- Acts of war that occur in Afghanistan, Algeria, Canada, Iran, Iraq, Pakistan, Syria, the United States or your country of residence. The maximum benefit for losses resulting from acts of war committed elsewhere is \$2 million per individual or \$20 million if several covered individuals suffer a covered loss as a result of the same accident.

Beneficiary designation

Your beneficiary for your business travel accident death benefit is the same as your associate basic life insurance beneficiary, unless you name a different beneficiary for business travel accident insurance. If you die without a surviving designated beneficiary, or if you are an hourly associate, benefits will be paid pursuant to the business travel accident policy.

Submitting claims

The Personnel Center will assist you or your beneficiaries for benefits under this plan.

Reimbursement Accounts

The Bank of America Health Care and Dependent Care Reimbursement Accounts are valuable tools for you and your family. You and your family members probably have some health care expenses that are not covered by medical, dental or vision insurance. Also, if you have children or elder dependents, paying someone to care for them so you can work can be costly. You can save money on these health care and dependent care expenses by paying for them with before-tax rather than after-tax dollars.

Here's how it works. You decide how much you want to contribute to one or both of the accounts when you enroll, by anticipating your eligible health care and dependent care expenses for the upcoming year. Each pay period, that money is deducted from your paycheck before it is taxed and then credited to your Health Care or Dependent Care Reimbursement Account. If you contribute to the Health Care Reimbursement Account, when you have a qualifying health care expense, you can pay using your Bank of America Health Care Card, or pay the bill another way and submit a claim for reimbursement. If you contribute to the Dependent Care Reimbursement Account, when you have a qualifying dependent care expense, such as child day care or elder care, you may pay at the time you receive a bill and submit a claim for reimbursement, or you may be able to have your dependent care provider paid directly from your account.

Both the Health Care Reimbursement Account and the Dependent Care Reimbursement Account are administered by WageWorks (**1.877.924.3967** or www.wageworks.com). Also, health care and dependent care savings calculators are available at www.wageworks.com. These calculators

can help you think about your eligible expenses for the year ahead, whether you should contribute to the Reimbursement Accounts, and how much to contribute.

NOTE: The two accounts are not interchangeable:

- You cannot use the contributions you make to the Health Care Reimbursement Account to pay for any dependent care expenses (such as day care expenses).
- Similarly, you cannot use the contributions you make to the Dependent Care Reimbursement Account to pay for any medical expenses (even if they are medical expenses of your dependent).

Health Care Reimbursement Account

Eligible Expenses

Eligible health care expenses include amounts not covered by insurance that you paid for the diagnosis, cure, mitigation, treatment or prevention of disease or illness, and for treatments affecting any part or function of the body. Except for insurance premiums, if a health care expense could be deducted for federal income tax purposes, it is an eligible expense. Any portion of a health care expense that is paid by other insurance is not eligible for reimbursement through the Health Care Reimbursement Account.

You may use your Health Care Reimbursement Account to cover expenses for yourself, your legal spouse and other individuals who are your dependents for federal tax purposes.

The following are examples of eligible expenses:

- Deductibles, coinsurance and copayments that you pay under your medical, dental and vision plans

- Treatment for alcoholism or drug dependency that exceeds medical plan limits
- Cost of special training to overcome mental or physical disabilities
- Prescription drugs and certain over-the-counter drugs
- Dental care, including orthodontia, unless of a cosmetic nature
- Vision and hearing care
- Smoking cessation program costs
- LASIK eye surgery
- Weight-reduction program as treatment for a specific disease (including obesity) diagnosed by a physician (not including the cost of low-calorie food, books and materials)
- Infertility treatment.

The following are examples of expenses **not** eligible for reimbursement:

- Premiums for any insurance coverage
- Fees for exercise, athletic or health club memberships
- Hair loss treatments or transplants
- Weight-reduction programs for general well-being
- Funeral or burial expenses
- Cosmetic procedures, except where necessary to improve a congenital deformity or disfigurement resulting from injury or disease
- Teeth whitening or bleaching
- Cosmetics or toiletries, such as toothpaste
- Dietary supplements, vitamins or other items purchased to maintain your general good health.

This list does not include every expense that may or may not be qualified. Refer to the IRS Publication 502, Medical and Dental Expenses, for a detailed list of eligible expenses. Contact WageWorks at **1.877.924.3967** or visit www.wageworks.com if you have additional questions.

Health and wellness

Reimbursement Accounts

How the plan works

When you first become eligible, and during each enrollment period, you must decide if you want to make before-tax contributions to the Health Care Reimbursement Account. Once you've enrolled for the plan year and decided how much to contribute, you cannot change or cancel your contributions (unless you have a qualified status change) until it's time to enroll again for the following year. If you do experience a qualified status change and wish to change or cancel your contributions, you must contact the Personnel Center within 31 days of the status change.

You may make before-tax contributions of between \$24 and \$5,000 during the plan year to your Health Care Reimbursement Account.

Internal Revenue Service regulations require that you use all the money in your account for expenses incurred in the same calendar year. Unused contributions are forfeited; they cannot be rolled over from one year to the next. The best way to avoid forfeiture is to make sure you have not overestimated your eligible expenses.

Using your account

Bank of America Health Care Card

When you enroll in the Health Care Reimbursement Account, you automatically receive a Bank of America Health Care Card, provided by WageWorks. You can use your card anywhere that accepts Visa®, including doctors' and dentists' offices, eyeglass and contact lens stores, health care Web sites and pharmacies. Eligible charges are automatically paid directly from your account, even if you have not yet contributed enough to cover the expense. You do not need to file claims for most expenses.

For any other eligible expenses that are not paid for using the Bank of America Health Care Card, you need to file a claim for reimbursement (see "Submitting a claim for reimbursement" which follows this section).

Submitting a claim for reimbursement

To file a claim for reimbursement, submit all the following to the reimbursement account administrator:

- A completed and signed Health Care Reimbursement Account claim form. You can obtain the form by calling the Personnel Center or by printing it from Personnel Online at personnelonline.bankofamerica.com.
- Documentation of your expense, consisting of one of the following: an itemized bill, an itemized receipt or explanation of benefits statement from your health plan.

Note: Any eligible expenses that are covered under another insurance plan must be filed with the appropriate carrier for processing and payment under that plan before you submit any unpaid part of the expense for reimbursement. You may submit claims at any time during the year. Reimbursements are deposited to the checking or savings account in which you receive your pay.

If you receive a payroll check, your reimbursement will be paid by check.

To be eligible for reimbursement, an expense must be incurred during a month in which you actively contribute to the account. An expense is incurred when you actually receive a service or make a purchase, not when you receive or pay a bill. If you leave Bank of America, your coverage ends on the last day of the pay period in which your employment ends. You may elect to continue coverage on an after-tax basis under COBRA health care coverage.

You have until March 31 following the end of the plan year to submit Health Care Reimbursement Account claims for expenses that you incurred while you contributed to the account.

Examples:

- Trisha has been contributing to the Health Care Reimbursement Account since the beginning of the year. She then has a qualified status change and elects to discontinue contributions to her account as of May 31. Only those expenses incurred between January 1 and May 31 are eligible for reimbursement. Trisha has until March 31 of the following year to submit her claims.
- Joseph incurs an eligible expense in December of the plan year he has made contributions to his Health Care Reimbursement Account. He does not receive the bill for the expense until the following March 15. Even if Joseph stopped contributing to his Health Care Reimbursement Account as of December 31, the claim is eligible for reimbursement as long as it is received by March 31.

Tax aspects of the Health Care Reimbursement Account

Medical expenses that are reimbursed from your account cannot be deducted on your federal income tax return that year. The amounts you contribute to your account reduce your wages for purposes of both income and Social Security taxes. Reducing your Social Security taxes could reduce your Social Security benefit slightly when you retire.

Dependent Care Reimbursement Account

If you are paying for dependent care services so that you can be employed, you may be able to use a Dependent Care Reimbursement Account to offset some of your dependent care costs. To be eligible to participate, you must be working or in active search of gainful employment; have eligible dependents; and either be single or have a spouse or domestic partner who is working, a full-time student, or disabled and unable to provide care.

Expenses eligible for reimbursement

If you meet the eligibility requirements, you can use your account to pay for, or reimburse, expenses incurred for the following individuals:

- Children younger than 13 for whom you are entitled to dependent exemptions on your federal income tax return
- Your spouse or other individuals who are your dependents for federal income tax purposes (such as a parent, domestic partner or a child age 13 or older) and who are unable to care for themselves.

If you and your dependents meet the eligibility requirements, you can use your account to reimburse your expenses for:

- Care provided inside your home for your eligible children or other dependents (including care provided by adult relatives you don't claim as dependents on your federal income tax return)
- Care provided outside your home for your eligible children or other dependents who regularly spend at least eight hours a day in your home.

Examples of eligible dependent care expenses include:

- Adult day-care centers
- Babysitting
- Before- and after-school programs
- Child day-care
- Elder care
- Preschool
- Senior day-care
- Sick child care
- Summer day camp.

You cannot use your account to pay or be reimbursed for expenses for food, clothing, education or entertainment. However, if these amounts are only a small amount of the total cost of caring for a qualified dependent, you can count the total cost. For example, if a nursery school provides lunch and educational services, you can count the entire cost. However, you may not count the cost of kindergarten if the program is primarily educational in nature and purpose, or for schooling in the first grade or higher. Expenses for an overnight camp, such as summer camp for children, are not reimbursable. If you have questions regarding the eligibility of an expense, call the Personnel Center to be connected to WageWorks.

How the plan works

When you first become eligible, and during each enrollment period, you must decide if you want to make before-tax contributions to the Dependent Care Reimbursement Account. Once you've enrolled for the plan year and decided how much to contribute, you cannot change or cancel your contribution (unless you have a qualified status change) until it's time to enroll again for the following year. If you do experience a qualified status change, you must contact the Personnel Center within 31 days of the status change. See "Changing your Dependent Care Reimbursement Account contributions during the year," later in this section.

If you are single, you may make before-tax contributions of between \$24 and \$5,000 during the plan year to your Dependent Care Reimbursement Account. If you are married and file a joint return, the maximum combined amount that you and your spouse can contribute to the Dependent Care Reimbursement Account and any other dependent care reimbursement account for which your spouse may be eligible is \$5,000. If you are married and file a separate return, the maximum amount you can contribute is \$2,500. The maximum contributions you may exclude from taxable income may be less if your and your spouse's earned income is less than \$5,000.

Internal Revenue Service regulations require that you use all the money in your reimbursement account for expenses incurred in the same calendar year. Unused contributions are forfeited; they may not be rolled over from one year to the next. The best way to avoid forfeiture is to make sure you have not overestimated your expenses.

Health and wellness

Reimbursement Accounts

Using your account

Direct payment

If you enroll in the Dependent Care Reimbursement Account, you may choose to register your dependent care provider information with WageWorks. If you do so, WageWorks will automatically pay your provider the dollar amount you specify, up to the amount in your account at that time. This eliminates the need to file claims for most expenses.

If you have an eligible expense that is not paid directly by WageWorks, you need to file a claim to receive reimbursement from your account. See "Submitting a claim for reimbursement" which follows this section.

Submitting a claim for reimbursement

To file a claim, submit all the following to the reimbursement account administrator:

- A completed and signed Dependent Care Reimbursement Account claim form. You can obtain the form by calling the Personnel Center or by printing it from Personnel Online at personnelonline.bankofamerica.com. The claim form must show the Social Security number of the person or the tax ID number of the facility providing the care.
- Documentation of your expense, consisting of one of the following: an itemized bill, itemized receipt or cancelled check.

You may submit claims at any time, but reimbursement will not be made for expenses you have not yet incurred. Also, if you submit a claim for expenses that exceed your account balance (contributions less reimbursements to date), those claims will be held and reimbursed once further contributions are made to your account.

To be eligible for payment from this account, an expense must be incurred during the plan year you are participating in the account, after your effective date of participation. You have until March 31 following the end of the plan year to submit your eligible expenses.

If you leave Bank of America, contributions to the Dependent Care Reimbursement Account will stop. If there is a balance remaining, you may submit claims up to the amount of the remaining balance for expenses incurred any time during the remainder of that plan year. You have until March 31 following the end of the plan year to submit your eligible expenses.

Example: Maria begins contributing to the Dependent Care Reimbursement Account when she is first eligible May 1. She then has a qualified status change and elects to stop contributing as of September 30. She may submit eligible dependent care expenses incurred between May 1 and December 31 for reimbursement up to the amount she contributed. Her claims must be submitted by March 31 of following year.

Changing your Dependent Care Reimbursement Account contributions during the year

You may be able to increase, decrease or stop contributions to the Dependent Care Reimbursement Account if one of the circumstances listed below occurs:

- Your dependent starts school and needs significantly less dependent care.
- There is a significant increase in the cost of dependent care, as long as the care provider is not a relative of the associate.
- You want to switch to a new dependent care provider.
- Your dependent reaches age 13 and becomes ineligible for dependent care assistance.

You cannot enroll mid-year solely because one of the above circumstances occurs.

To make a status-related benefit change, you need to call the Personnel Center within 31 days of the date your qualified status change occurs. Otherwise, you will have to wait until the next annual enrollment period to make changes.

Tax aspects of dependent care assistance programs

You should be aware of two tax issues that may affect your participation in the Dependent Care Reimbursement Account and the Child Care Plus program offered by Bank of America: There is a limit on how much dependent care assistance you can receive before it becomes taxable. Depending on your tax bracket, instead of contributing to the Dependent Care Reimbursement Account, you may want to claim the federal dependent care tax credit (for expenses beyond those reimbursed under Child Care Plus).

See the “Benefits at a glance” table at the beginning of this handbook to learn more about Child Care Plus, or contact the Personnel Center.

Income tax exclusion for dependent care assistance benefits

The Internal Revenue Code limits the amount of dependent care assistance you can receive each year that is not taxed. Payments from the Dependent Care Reimbursement Account and the Child Care Plus program are added together to count towards this nontaxable limit. If your spouse receives benefits from another employer, this amount counts too. The annual limit is equal to the smallest of:

- Your earned income
- Your spouse’s earned income (even if not working, your spouse is deemed to have some earned income if disabled or a full-time student)
- \$5,000, if you are single
- \$5,000, if you are married filing jointly
- \$2,500, if you are married and filing a separate tax return.

Example: Melissa earns \$17,000 at Bank of America, and her spouse earns \$4,000. They file a joint federal income tax return. Under the rules above, the maximum amount of nontaxable dependent care assistance they can receive is \$4,000 (the amount of spouse’s earned income). Any amount of dependent care assistance they receive over \$4,000 is included in their taxable income.

Dependent care federal tax credit

The dependent care tax credit allows you to subtract a percentage of your qualifying dependent care expenses from your taxes.

If you are in a low federal income tax bracket, it may be better for you to pay some or all of your dependent care expenses (beyond those reimbursed under Child Care Plus) with after-tax dollars and claim the federal tax credit for dependent care expenses, instead of contributing to the Dependent Care Reimbursement Account for those expenses. This is because the dependent care tax credit may reduce your taxes more than the before-tax contributions to the reimbursement account.

Note: It will always be beneficial for you to take advantage of Child Care Plus, if you qualify.

The maximum amount of qualifying expenses you can count for the dependent care tax credit is \$3,000 for one child and \$6,000 for two or more children. The tax credit is equal to 20% to 30% of these amounts, based on your adjusted gross income for federal income tax purposes. These maximum amounts of qualifying expenses are reduced dollar-for-dollar by the amount of reimbursements you receive from the Dependent Care Reimbursement Account and Child Care Plus.

Example: Jane has one eligible child and receives \$2,000 from Child Care Plus. The maximum amount of qualifying expenses she can count towards her dependent care tax credit computation in a calendar year will be \$1,000 (\$3,000 minus \$2,000), even if she spent more than that for dependent care expenses.

To determine whether the federal dependent care credit or the Dependent Care Reimbursement Account is best for you, you need to first estimate your adjusted gross income for the tax year. Then compare (1) your top incremental income tax bracket and (2) your dependent care tax credit percentage. If your income tax bracket is higher, the Dependent Care Reimbursement Account will usually be the better choice for you.

In addition, LifeWorks is a free, confidential resource offering financial counseling with consultants available to answer your tax questions. You can also refer to IRS Publication 503 entitled “Child and Dependent Care Expenses” or talk to your own tax advisor for more detailed information.